CARE
BANGLADESH

CHILD HEALTH INITIATIVES FOR LASTING DEVELOPMENT PROJECT

CHILD (CS VIII)

Project Dates: October 1, 1991- August 31, 1995

FINAL EVALUATION REPORT

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A.I.D.

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Special thanks goes to all of the health and family planning workers who, day in and day out are walking the long distances, in the mud this time of year, to provide health and family planning services. Their work is not often directly acknowledged. Without it, all of the national targets would be just targets and not the reality that they have become in Bangladesh, and CHILD would be just and idea.

USAID is acknowledged for their funding of this evaluation and the CHILD Project. CARE-USA and The Australian High Commission are also acknowledged for their funding of the CHILD Project in Sylhet.

ACRONYMS

AH1	=	Assistant Health Inspector
CDD	=	Control of Diarrheal Diseases
CHILD	=	Child Health Initiative for Lasting Development
COSAS	=	Coverage Survey Analysis Software
c s	=	Civil Surgeon (MOHFW)
c u	=	Coordination Unit
DD-FP	=	Deputy Director Family-Planning (MOHFW)
DIP	=	Detailed Implementation of Plan
DG	=	Director General
EPI	=	Expanded Program on Immunization
FE	=	Field Extensionist
FP	=	Family Planning
FPI	=	Family Planning Inspector
FT	=	Field Trainer
FW	=	Field Worker
FWA	=	Family Welfare Assistant (MOHFW)
FWC	=	Family Welfare Center
FWV	=	Family Welfare Visitor (MOHFW)
GOB	=	Government of Bangladesh
HA	=	Health Assistant (MOHFW)
HI	=	Health Inspector (MOHFW)
HIS	=	Health Information System of CHILD Project
IEDCR	=	Institute for Epidemiological Disease Control Research
IPC	=	Interpersonal Communications
K&P	=	Knowledge and Practice Survey
MCH	=	Maternal and Child Health
MIS	=	Management Information System (MOHFW)
MOHFW	=	Ministry of Health and Family Welfare
MTE	=	Mid-Term Evaluation
NCDDP	=	National Control of Diarrheal Diseases Program
NGO	=	Non Government Organization
NID	=	National Immunization Day
ORS	=	Oral Rehydration Solution
ORT	=	Oral Rehydration Therapy
PVO/CSSP	=	Private Voluntary Organization/Child Survival Support Program
SC	=	Satellite Clinic
SI	=	Sanitary Inspector (MOHFW)
TBA	=	Traditional Birth Attendant
THFPO	=	Thana Health and Family Planning Officer (MOHFW)
TFPO	=	Thana Family Planning Officer (MOHFW)
THC	=	Thana Health Complex

TIC A	=	Training Immunizers in the Community Approach
TPM	=	Team Planning Meeting
TT	=	Tetanus Toxoid
USAID	=	United States Agency for International Development
VAC	=	Vitamin A Capsules
WER	=	Weekly Epidemiological Report

OTHERINJ?ORMATION

Dhaka : Capital of Bangladesh

Sylhet : One of the six divisions in Bangladesh (The others are Dhaka, Chittagong, Khulna, Rajshahi, Barisal)

Sylhet District: One of the 4 administrative districts in Sylhet Division (On August 1, 1995 Sylhet District became part of the newly created Sylhet Division, prior to that it was part of Chittagong Division).

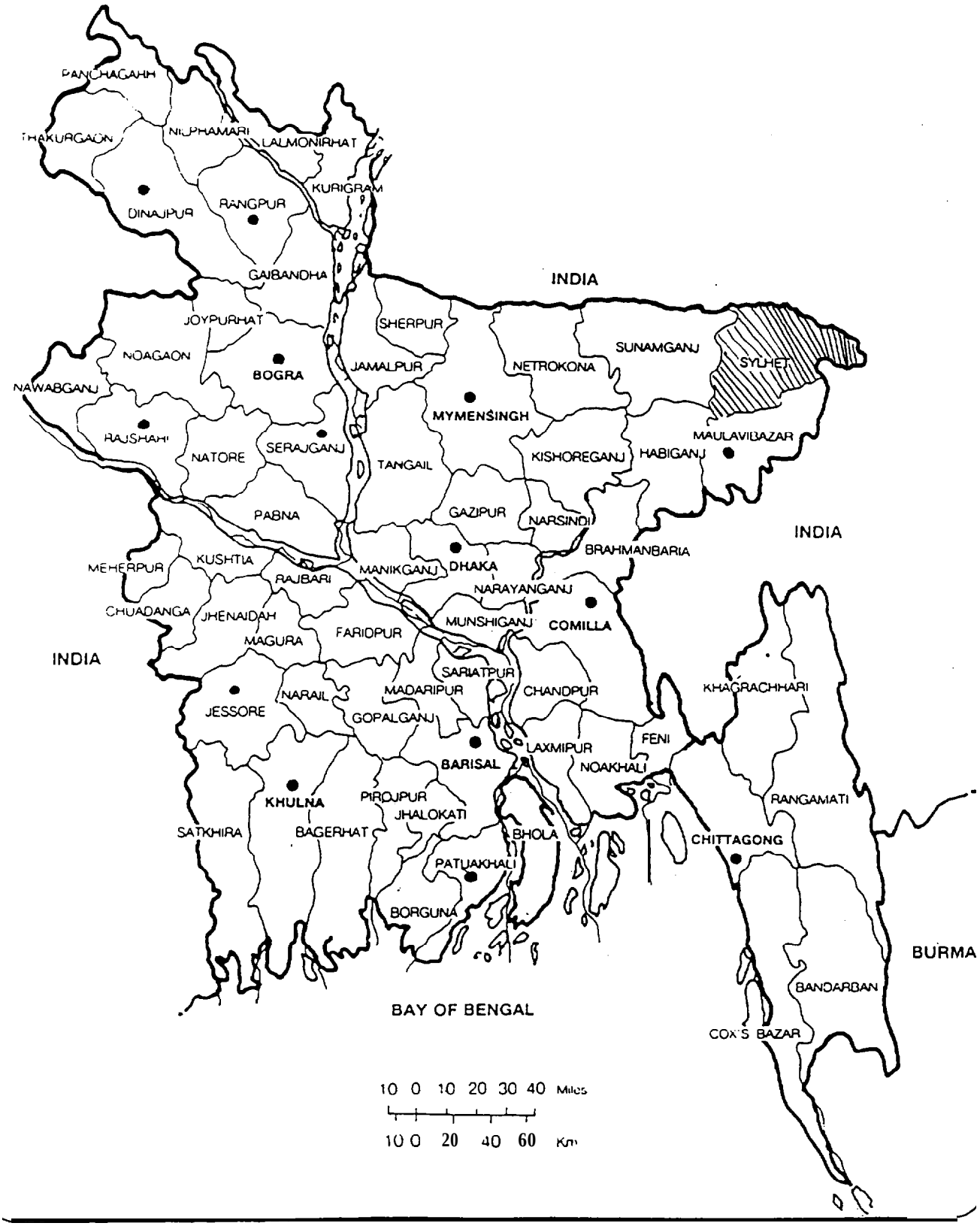
Administrative units:

Thana: Administrative unit serving an estimated population of 200,000; 11 Thanas in Sylhet District.

Union: Administrative unit serving an estimated population of 20,000; 141 unions in Sylhet District.

Ward: Subdivision of a union (3 wards per union) with 6-7000 pop.; 423 wards in Sylhet District.

BANGLADESH DISTRICT MAP



EXECUTIVE SUMMARY

In October 1991, CARE Bangladesh, in collaboration with the Ministry of Health and Family Welfare (MOHFW) and funding from CARE and USAID, began the Child Health Initiatives for Lasting Development (CHILD) Project, in five of the eleven Thanas of Sylhet District. This Child Survival (CS) project focused on building sustainable improvements to the MOHFW infrastructure, to increase the utilization of the following interventions:

- Expanded Program on Immunizations (EPI),
- Control of Diarrheal Disease (CDD),
- Vitamin A Capsule Distribution (VAC), and
- Family Planning (FP).

From the beginning, CHILD has worked through and with the MOHFW, by providing training and technical assistance in the field, to improve existing services in Sylhet. During this period, no additional workers were recruited by CHILD. After four years of work, in five of the thanas of Sylhet, an evaluation of CHILD was undertaken to document the successes and help to provide lessons for the future CHILD II Project.

The evaluation team reviewed CHILD documents and visited the CHILD Project site in Sylhet to gather first-hand qualitative information on the work of CHILD over the last four years. The team was comprised of two external consultants and three members who were very familiar and active with CHILD. Additionally, CHILD conducted a final Knowledge and Practice survey (K&P) that was able to quantify the results of the Project through a direct comparison of the 199 1 baseline (annual K&P surveys were also done in 1992 and 1994) with another 1995 K&P survey in the six thanas where CHILD did not work.

RESULTS

The work of CHILD has been well appreciated at all levels of the MOHFW and down to the community level. This was particularly strong among those who worked in EPI. EPI Technicians and Health Assistants (HA) were uniformly appreciative of the training that they received and expressed that they were now much more confident in their work. Finally, these workers expressed that they were now more skilled in their jobs. HAs and EPI Technicians in CHILD areas appeared to be better organized and providing better services than the Non-CHILD areas. Additionally EPI Technicians and HAs indicated that they would be able to continue doing the improved work once. CHILD finished in their Thana.

At the community level, there was a recognition that Family Planning and Health services, particularly satellite and outreach sites were more regular and integrated in the CHILD areas. Community members did not recognize CHILD workers as coming from CHILD. They were identified as part of the team coming from the "Thana Hospital". Thus CHILD was very well integrated into the MOHFW infrastructure.

Based on the final K&P Survey, the greatest improvement, among the indicators spelled out in the Detailed Implementation Plan (DIP), was seen for EPI.

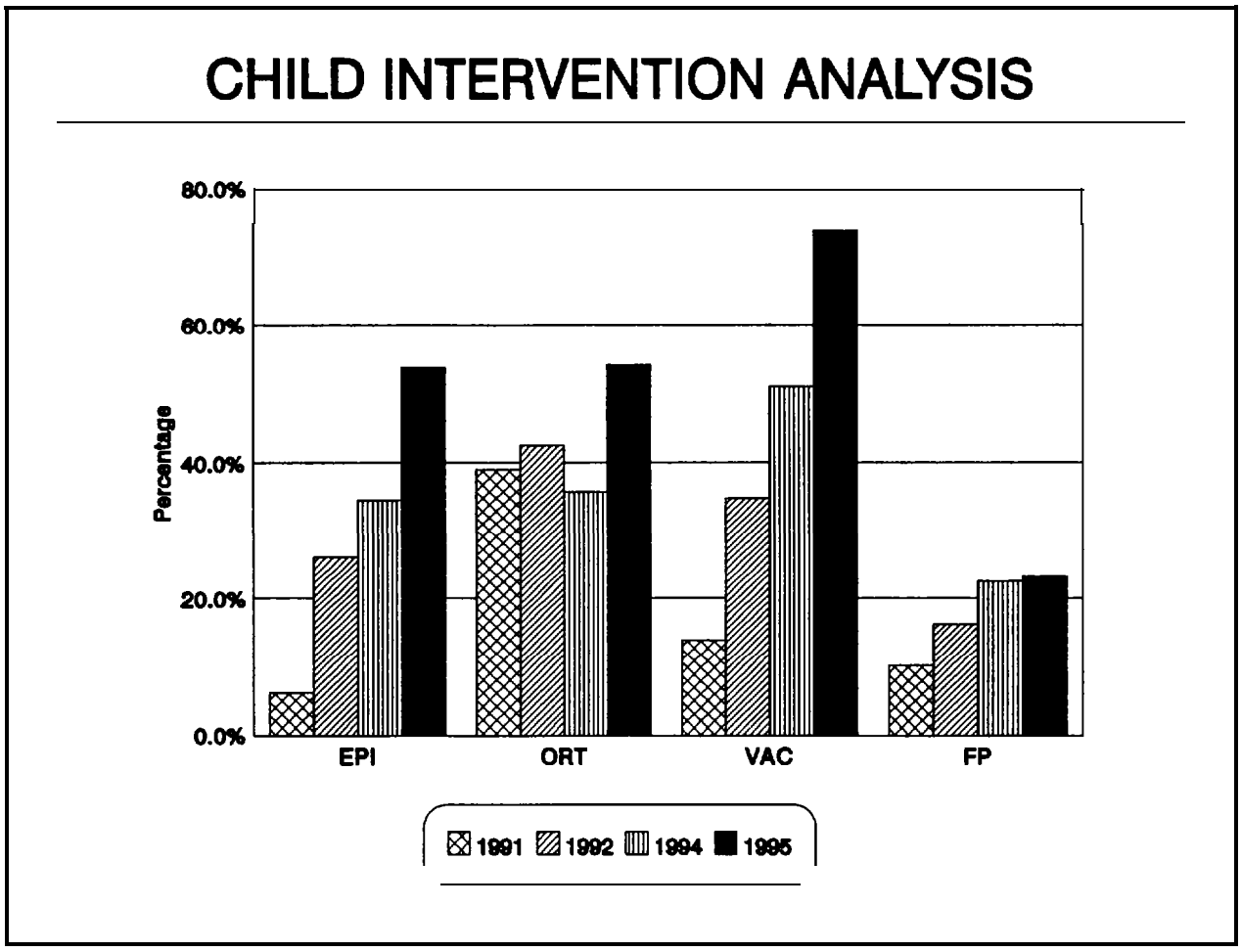


Figure 1

- **Expanded Program on Immunizations**

  Figure 1 shows how the EPI coverage for children 12-23 months of age, completely vaccinated, increased from 6% in 1991 to 54% in 1995. This impressive result was achieved by improving the existing system of the MOHFW in Sylhet, rather than by CHILD staff. This gain is all the more impressive when you consider that Sylhet is considered to be one of the most difficult places to work in Bangladesh. By comparison, in the Non-CHILD thanas the coverage is only 16% in 1995. CHILD used no new direct service providers to achieve this result.

  Figure 1 also illustrates the gains made in three of the other interventions measured in the K&P Survey.

- **Control of Diarrhea1 Disease**

  The use of Oral Rehydration Therapy (ORT) for children under two with diarrhea, that occurred in the last two weeks preceding the survey, increased from 39% to 54%.

- **Vitamin A Capsules Distribution**

  CHILD increased the percentage of children less than two receiving a VAC in the last six months from 16% to 74%, well beyond the objective set out in the original DIP, 50%.

- **Family Planning**

  Under CHILD, the proportion of mothers with a child less than two and not pregnant, using any type of contraception was more than doubled from 10% in 199 1 to 23 % in 1995. This result is all the more dramatic when it is compared to the Non-CHILD areas of Sylhet, which is at the 8 % level in 1995. While the evaluation team saw evidence of more acceptance of FP in Sylhet, this is still an area of Bangladesh that is well behind, in terms of CPR, when compared to the rest of Bangladesh.

CHILD has also had a number of other achievements that demonstrate the improvements that have been obtained with the approach of working with the MOHFW in Bangladesh.

- The first is an effective integration of outreach and satellite services in the CHILD areas: since January 1995, over 90% of the sites are merged.

- Secondly, CHILD staff have helped to develop the problem-solving skills of their various counterparts. This was particularly evident in how MOHFW monthly meetings, at the thana level, are now effectively dealing with how to improve the system of service delivery.

- CHILD has helped the MOHFW to identify high risk populations and develop tailored approaches to reaching those populations, such as the work in reaching the families of tea garden workers.

- Finally, CHILD has helped to develop the skills of MOHFW workers, in the field and at the supervisory level, resulting in more community mobilization and more regular and better quality services in the CHILD areas. Health workers have truly learned and convinced themselves, from the example of CHILD staff, that they can mobilize the communities.

RECOMMENDATIONS FOR THE NEXT PHASE OF CHILD

- CHILD II needs to expand, in a phased manner, from the present 5 thanas to include the remaining 6 thanas of Sylhet District. CHILD II should focus on increasing the utilization of, and improving quality of services at outreach and satellite sites.

- CHILD II should develop the community mobilization and participation strategy that has been accomplished in the original 5 thanas in the new thanas of CHILD II. This is an area where CHILD has repeatedly showed MOHFW staff how to accomplish community based-work. The hands on-approach has worked well and needs to be an integral part of the work in CHILD II.

- Future EPI work should include disease control and surveillance activities. Additionally, CHILD should develop the use of mapping techniques at the THC level for better visualization of service coverage and eventual disease mapping.

- CHILD II should build on the work of CHILD in the areas of health education, particularly the participatory approach to adult learning and Child to Child activities. In the area of CDD, there needs to be a more targeted approach toward education about the need to continued feeding during episodes of diarrhea.

- During the visit of the team, it was expressed several times that there is a need to integrate Traditional Birth Attendants (TBA) into the national FP program. In some CHILD areas, the team observed TBAs bringing mothers to the satellite clinics. How to use these community resources is an important issue to address, particularly in Sylhet where it is difficult to recruit and keep female community workers.

- CHILD needs to prepare documentation on lessons that it has learned so that they can be more easily shared with the MOHFW and other NGOs, as well as widely disseminated to others within and outside of Bangladesh.

- The overall Health Information System (HIS) of the CHILD Project needs to be reviewed for simplification and better presentation of the information, i.e. graphical rather than tabular. There also needs to be more emphasis placed on the sharing of the information, with the MOHFW, once it is in a more user-friendly format.

CONCLUSIONS

CHILD has demonstrated three important achievements in terms of a partnership strategy between a NGO and the MOHFW:

- Working with the MOHFW at the field level is an effective way of improving child survival services, particularly in low performing areas.

- Collaboration for sustained institutional strengthening is possible and effective as long as the NGO inputs are not substituting for GOB workers and responsibilities.

- Stronger coordination and collaboration, between the "wings" of the MOHFW, is possible and results in improved service delivery and better community acceptance of health and family planning services.

BANGLA EXECUTNE SUMMARY

কার্যকরী সারাংশ

শিশুস্বাস্থ্য স্থায়ী উন্নয়ন উদ্যোগ বা *চাইল্ড হেল্‌থ্‌ ফর লাস্টিং ডেভলপ্‌মেন্ট* (*চাইল্ড*) হলো *কেয়ার, বাংলাদেশ*–এর একটি শিশুরক্ষা (চাইল্ড সার্ভাইভাল) প্রকল্প। এ প্রকল্পটি শুরু হয় ১৯৯১ সালের অক্টোবর মাসে। বাংলাদেশ সরকারের স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়–এর সহযোগিতায় এবং *কেয়ার, ইউ.এস.এ.*–এর অর্থানুকুল্যে *চাইল্ড*–এর কার্যক্রম পরিচালিত হয়। এর আওতাভুক্ত এলাকা হলো সিলেট জেলার মোট এগারোটি থানার মধ্যে পাঁচটি থানা। এ শিশুরক্ষা প্রকল্পটি স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়–এ দীর্ঘস্থায়ী উন্নতির দিকে দৃষ্টি দেয়, যাতে নিম্নলিখিত ক্ষেত্রসমূহে তৎপরতা বৃদ্ধি পায় :

- সম্প্রসারিত টিকদান কর্মসূচী (ই.পি.আই.)
- উদরাময় রোগ নিয়ন্ত্রণ (সি.ডি.ডি.)
- ভিটামিন–এ ক্যাপসুল বিতরণ (ভি.এ.সি.) এবং
- পরিবার পরিকল্পনা (এফ.পি.)

মাঠ–পর্যায়ে প্রশিক্ষণ ও কারিগরী সহযোগিতা প্রদানের মাধ্যমে সিলেটের বিরাজমান কার্যক্রমের উন্নয়নে, *চাইল্ড* শুরু থেকেই পূর্বোক্ত মন্ত্রণালয়ের মাধ্যমে ও তার সাথে কাজ করে যাচ্ছে। এই সময়কালের ভেতর, *চাইল্ড*–এর জন্য কোন বাড়তি কর্মী নিয়োগ করা হয় নি। সিলেটের পাঁচটি থানায় চার বছর কার্যক্রম চালানোর পর *চাইল্ড*–এর মূল্যায়নের উদ্যোগ নেয়া হয়েছে যাতে করে এর সাফল্য লিপিবদ্ধ করা যায় এবং ভবিষ্যতের জন্য, *চাইল্ড*–২ প্রকল্পের জন্য, সহায়তামূলক শিক্ষাবলী নির্দেশ করা সম্ভব হয়।

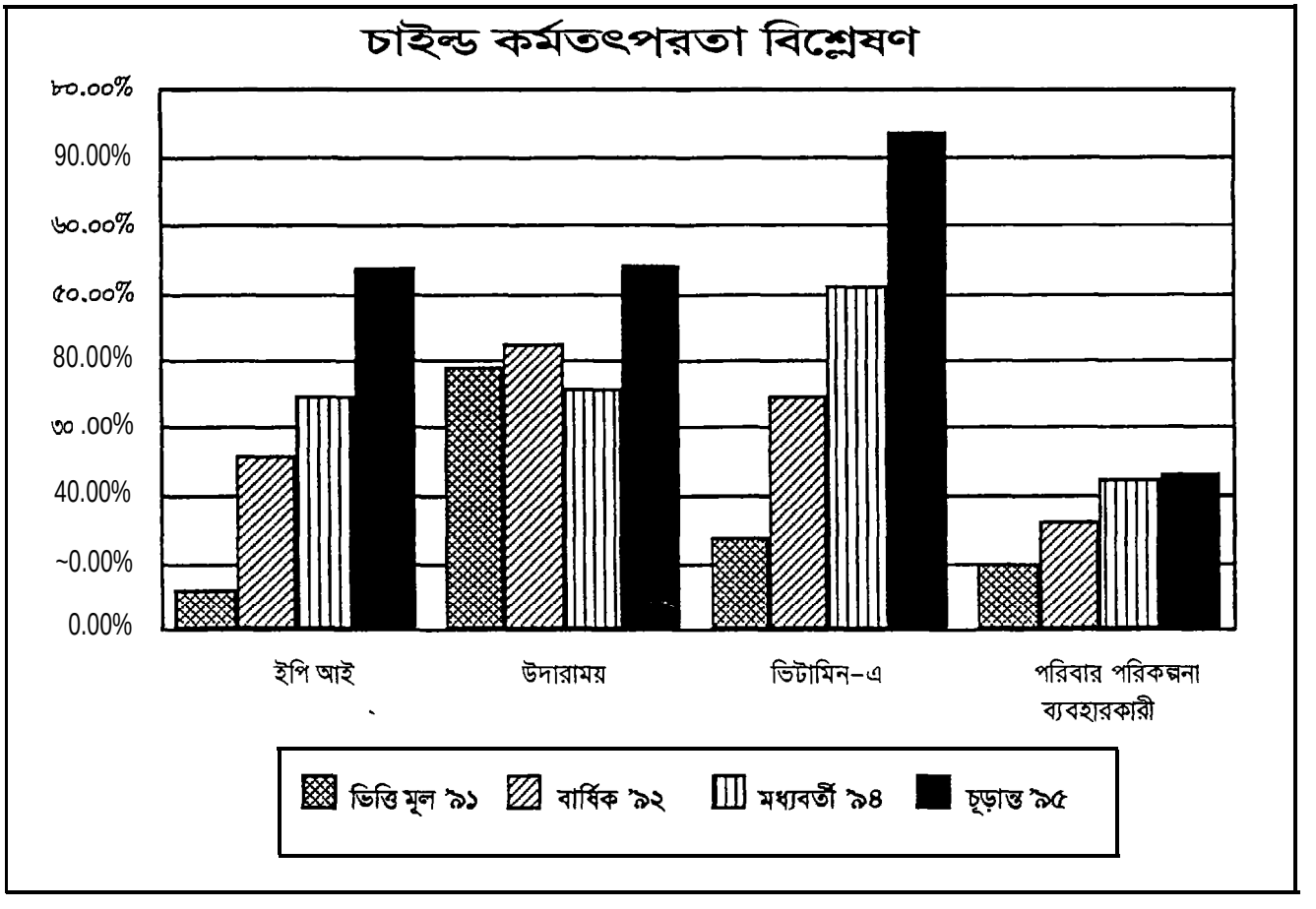
মূল্যায়নদলটি, *চাইল্ড*–এর গত চার বছরের কাজ সম্পর্কে প্রত্যক্ষ গুণগত তথ্য জানার জন্য, *চাইল্ড*-এর দলিলসমূহ পর্যালোচনা করেছে ও সিলেটে প্রকল্প এলাকা পরিদর্শন করেছে। এ দলটি গঠিত হয় দু'জন চাইল্ড–বহির্ভূত কন্সাল্‌ট্যান্ট এবং *চাইল্ড*–এর সাথে অধিক পরিচিত ও সক্রিয় তিনজন সদস্য নিয়ে। এর সাথে যুক্ত হয়েছে চাইল্ড–এর ১৯৯৫ **চূড়ান্ত জ্ঞান ও অভ্যাস** (*নলেজ অ্যান্ড প্র্যাক্টিস*) **জরীপ**, যাতে প্রকল্পটির ফলসমূহ ১৯৯১ সালে পরিচালিত ভিত্তিমূল (বেজ্‌লাইন) জরীপের সাথে সংখ্যাবাচক দিক থেকে সরাসরি তুলনা করা যায় (১৯৯২ ও ১৯৯৪ সালেও **বার্ষিক জ্ঞান ও অভ্যাস জরীপ** করা হয়েছিল)। *চাইল্ড* যে ছ'টি থানায় কাজ করেনি তাতেও পরিচালিত অপর একটি **জ্ঞান ও অভ্যাস জরীপ ১৯৯৫** এর সাথেও প্রতিতুলনা করা হয়।

ফলসমূহ

স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের সকল স্তরে এবং একেবারে গণ (বা কমিউনিটি) স্তরে *চাইল্ড*–এর কাজ বেশ প্রশংসিত হয়েছে, বিশেষ করে সম্প্রসারিত টিকাদান কর্মসূচীর ক্ষেত্রে। সকল ইপিআই টেকনিশিয়ান ও স্বাস্থ্য সহকারী, প্রাপ্ত প্রশিক্ষণ সম্পর্কে ভাল বলেছেন ও নিজেদের কাজের ক্ষেত্রে আরো আত্মবিশ্বাসী হয়েছেন। মোদ্দাকথা, এই কর্মীবৃন্দ নিজেদের কাজ করায় আরো দক্ষ হয়েছেন। পর্যবেক্ষণে দেখা গেছে, *চাইল্ড*–বহির্ভূত এলাকার চেয়ে *চাইল্ড* এলাকায় স্বাস্থ্য সহকারী ও ইপিআই টেকনিশিয়ানগণ অধিক সুসংগঠিত এবং ভালভাবে সেবাপ্রদান করছেন। এও বলা দরকার যে, *চাইল্ড*–এর কাজ সমাপ্ত হলেও উক্ত স্বাস্থ্যকর্মীবৃন্দ তাদের সেবাকর্মের উন্নততর মান বজায় রাখতে পারবেন বলে আশাবাদ ব্যক্ত করেছেন।

পরিবার পরিকল্পনা ও স্বাস্থ্য সেবার স্বীকৃতি পাওয়া যায় গণস্তরে, নির্দিষ্টভাবে বলতে গেলে *চাইল্ড* এলাকায় স্যাটিলাইট ক্লিনিক ও মাঠ পর্যায়ের ইপিআই টিকাদান কেন্দ্র নিয়মিতভাবে অনুষ্ঠিত হয় এবং এই দুইয়ের মধ্যে সমন্বিত কার্যক্রম লক্ষ্য করা গেছে। গ্রামের জনসাধারণ *চাইল্ড* কর্মীদেরকে সরকারী কর্মী থেকে পৃথক মনে করেন না। তাদেরকে দেখা হয় "থানা হাসপাতাল" থেকে আসা কর্মীদলের অংশ হিসেবে। কাজেই বোঝা যায় যে পূর্বোক্ত মন্ত্রণালয়ের অবকাঠামোর সাথে *চাইল্ড* ভালভাবেই সমন্বিত হয়েছে।

জ্ঞান ও অভ্যাস চূড়ান্ত জরীপের ওপর ভিত্তি করে বিস্তারিত বাস্তবায়ন পরিকল্পনার (*ডিটেইল্ড ইম্‌প্লিমেন্টেশন প্ল্যান*– ডি.আই.পি.) সূচকগুলি থেকে দেখা যায়, সম্প্রসারিত টিকাদান কর্মসূচীর ক্ষেত্রে সবচেয়ে বেশী উন্নতি ঘটেছে।



চিত্র — ১

- সম্প্রসারিত টিকাদান কর্মসূচী

  চিত্র–১ দেখা যায়, সম্প্রসারিত টিকাদান কর্মসূচীর অধীনে ১২ থেকে ২৩ মাস বয়স্ক শিশুদের মধ্যে মাত্র ৬% শিশু ১৯৯১ সালে সম্পূর্ণরূপে টিকা গ্রহণ করেছে। ১৯৯৫ সেটা বেড়ে দাঁড়ায় ৫৪%–এ। এই আকর্ষণীয় ফলাফল *চাইল্ড* কর্মীদের অর্জন নয়, বরং তা অর্জিত হয়েছে সিলেটের বিরজমান স্বাস্থ্য ও পরিবার কল্যাণ ব্যবস্থাকে উন্নত করার মাধ্যমেই। এই সাফল্য আরো বিশেষ গুরুত্ববহ হয়ে উঠে যখন আমরা মনে রাখি যে, সিলেট হচ্ছে বাংলাদেশের মধ্যে এ রকম এলাকা যেখানে এই ধরণের কাজ করা খুবই কঠিন। *চাইল্ড*–বহির্ভূত থানার একই তথ্য বিচার করলে দেখা যায় সেখানে সম্পূর্ণরূপে টিকা গ্রহণ করেছে এমন শিশু ১৯৯৫ সালে মাত্র ১৬%। উল্লেখ্য যে এ ফলাফল অর্জন করতে *চাইল্ড* কোন নতুন ও প্রত্যক্ষ সেবা প্রদান করে নি।

জ্ঞান ও অভ্যাস জরীপ–এ হিসেব করা অপর তিনটি ক্ষেত্রের সাফল্য চিত্র ১–এ দেখানো হয়েছে।

- **উদরাময় রোগ নিয়ন্ত্রণ**

  জরীপ শুরু হবার দু'সপ্তাহ পূর্বে দু'বছর কম বয়স্ক যে সব শিশু উদরাময় আক্রান্ত হলে খাবার স্যালাইন ব্যবহার করা হয়েছে স্যালাইন ব্যবহারকারী এমন শিশুর হার ১৯৯১ সালে যেখানে ছিল ৩৯% সেখানে ১৯৯৫ সালে তা বৃদ্ধি পেয়ে দাঁড়ায় ৫৪%–এ।

- **ভিটামিন এ ক্যাপসুল বিতরণ**

  আগের ছয় মাসে ভিটামিন 'এ' ক্যাপসুল বিতরণের শতকরা হার *চাইল্ড* এলাকায় ১৬% থেকে ৭৪%–এ বাড়ানো সম্ভব হয় (দু'বছরের কম বয়সী শিশুর ক্ষেত্রে), যা কি না মূল বিস্তারিত বাস্তবায়ন পরিকল্পনা (ডি আই পি)–র লক্ষ্য থেকেও বেশি।

- **পরিবার পরিকল্পনা**

  চাইল্ড–এর এলাকায় দু'বছরের কমবয়স্ক সন্তান রয়েছে ও গর্ভবতী নন এমন মায়েদের মধ্যে যারা জন্মনিয়ন্ত্রণ পদ্ধতি ব্যবহার করছেন তাদের হার ১৯৯১–এর ১০% থেকে ১৯৯৫–এ বেড়ে দাঁড়ায় ২৩%। এ সাফল্য *চাইল্ড* বহির্ভূত সিলেট-এর থানাগুলির সাথে তুলনা করলে আরো নাটকীয় মনে হয়, যা ১৯৯৫ সালেও মাত্র ৮%। যদিও মূল্যায়ন-দল সিলেটে পরিবার পরিকল্পনা গ্রহণ বৃদ্ধি পাবার সাক্ষ্য পেয়েছে তবুও জন্মনিয়ন্ত্রণ ব্যবস্থা গ্রহণের হার (সিপিআর)–এর দিক থেকে বাংলাদেশের এ অঞ্চল অন্যান্য অঞ্চলের থেকে অনেক পিছিয়ে।

চাইল্ড–এর আরো কিছু সংখ্যক সাফল্য দেখতে পাওয়া যায়, যা কিনা বাংলাদেশের স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের সাথে কাজ করার দৃষ্টিভঙ্গী সম্পন্ন কর্মপদ্ধতি গ্রহণ করার ফলশ্রুতি।

- প্রথমটি হলো, *চাইল্ড* এলাকাতে গ্রামীণ টিকাদান কেন্দ্র ও স্যাটিলাইট ক্লিনিকগুলো কার্যকরভাবে সমন্বিত সেবা দান করছে, জানুয়ারী ১৯৯৫-এ যার হার ৯০% এর অধিক।

- দ্বিতীয়তঃ *চাইল্ড* কর্মীবৃন্দ বিভিন্ন সরকারী কর্মীদের সমস্যা–সমাধানের–দক্ষতা বৃদ্ধি করেছে। আলোচ্য মন্ত্রণালয়ের অধীনস্থ থানা পর্যায়ে অনুষ্ঠিত মাসিক মিটিংগুলি কিভাবে সেবা প্রদানের পদ্ধতির উন্নয়ন করছে সে ক্ষেত্রটি বিবেচনা করলে এটি বিশেষভাবে সুস্পষ্ট হয়ে উঠে।

- *চাইল্ড* উচ্চ ঝুঁকিপূর্ণ জনসংখ্যা (high risk population) নির্ণয়ে আলোচ্য মন্ত্রণালয়কে সাহায্য করেছে এবং জনসাধারণের কাছে স্বাস্থ্যসেবা আরো সুসমন্বিত পদক্ষেপে পৌছানোর ব্যাপারে সাহায্য করেছে। যেমন চা–বাগান শ্রমিকদের পরিবারে কাজ করার ক্ষেত্রে এটি উল্লেখযোগ্য।

- সবশেষে উল্লেখ করা যায় যে *চাইল্ড*, মাঠ ও পরিদর্শক স্তরে, স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মীদের দক্ষতা বৃদ্ধিতে সাহায্য করেছে, যার ফলে *চাইল্ড* এলাকায় নিয়মিত গণ-সমাবেশ ঘটছে এবং আরো নিয়মিত সেবাপ্রদান করা হচ্ছে। স্বাস্থ্য কর্মীবৃন্দ সত্যি–ই শিখেছেন এবং নিজেদের বোঝাতে পেরেছেন, *চাইল্ড* কর্মীদের মতো তারাও গণসমাবেশ করতে সক্ষম।

চাইল্ড—এর পরবর্তী ধাপের জন্য সুপারিশ

- *চাইল্ড ২* প্রকল্প ধাপে ধাপে সম্প্রসারণ ঘটানো উচিত যাতে বর্তমানে যে ৫টি থানায় কাজ রয়েছে তার সাথে সিলেটের বাকী ছয়টি থানা যুক্ত করা যায়। প্রয়োগ নৈপুণ্য বৃদ্ধি ও উন্নতমানের সেবা প্রদান করার জন্য গ্রামীন টিকাদান কেন্দ্র ও স্যাটেলাইট ক্লিনিকগুলির প্রতি *চাইল্ড-২*-এর দৃষ্টি কেন্দ্রিভূত করা উচিত।

- মূল ৫টি থানায় গণ সমাবেশ ও সরকারের সাথে অংশগ্রহণের কর্মকৌশল গ্রহণের মাধ্যমে *চাইল্ড* যে সাফল্য অর্জন করেছে তা *চাইল্ড ২*–এর নতুন থানায় প্রসারিত করতে হবে। গণভিত্তিক কাজে সাফল্য লাভে স্বাস্থ্য ও পরিবারকল্যাণ কর্মকর্তাদেরকে *চাইল্ড* বার বার উৎসাহিত করেছে। হাতেনাতে শেখানো পদ্ধতি ভাল কাজ করেছে এবং *চাইল্ড ২*–এর কাজেও তা প্রয়োজনীয় হিসেবে দেখা দেবে।

- ভবিষ্যতে সম্প্রসারিত টিকাদান কর্মসূচী রোগ নিয়ন্ত্রণ ও রোগ–সন্ধান (সার্ভেইল্যান্স) কর্মকান্ড যুক্ত করা উচিত। এরই সাথে, *চাইল্ড* থানা স্তরে মানচিত্রায়ণের পদ্ধতি ব্যবহার করে সেবা ক্ষেত্র ও রোগীর আবাস মানচিত্রের মাধ্যমে দৃশ্যমান করে তুলতে সচেষ্ট হবে।

- *চাইল্ড*–এর অভিজ্ঞতা ওপর ভিত্তি করে *চাইল্ড ২* কাজ করবে স্বাস্থ্যশিক্ষা ক্ষেত্রে, বিশেষত: শিশু হ'তে শিশু (Child-to-Child) কর্মকান্ডে অংশগ্রহণ পদ্ধতির মাধ্যমে শিক্ষণ। উদারাময় নিয়ন্ত্রণের ক্ষেত্রে আরো সুনির্দিষ্ট পদক্ষেপ নেয়া প্রয়োজন যাতে উদরাময়কালীন খাদ্যগ্রহণের পরিমাণ বৃদ্ধির ওপর জোর দেয়া হয়।

- চিরাচরিত দাই (Traditional Birth Attendant-TBA) দেরকে জাতীয় পরিবার পরিকল্পনা কর্মসূচীতে সুসমন্বিত করার জন্য পদক্ষেপ গ্রহণের প্রস্তাব মূল্যায়ন দলের পরিদর্শনের সময় বার কয়েক উত্থাপন করা হয়েছে। কিছু *চাইল্ড* অঞ্চলে দলটি দেখেছে দাইয়েরা স্যাটেলাইট ক্লিনিকে মা–দের নিয়ে আসছে। কিভাবে এই গণ–সম্পদ ব্যবহার করা যায় তা গুরুত্বপূর্ণ, বিশেষ করে সিলেট অঞ্চলে, যেখানে গণপর্যায়ে–কর্মী সংরক্ষণ ও নিয়োগ করা কঠিন।

- *চাইল্ড*–এর অভিজ্ঞতালব্ধ শিক্ষাবলী আরো লিপিবদ্ধ করা দরকার যাতে সরকার ও অন্যান্য এনজিও–দের সাথে তা বিনিময় করা যায়। বাংলাদেশের ভেতর ও বাইরে *চাইল্ড*–এর অর্জিত শিক্ষামালা ব্যাপকভাবে জানানোর পদক্ষেপ নেওয়া দরকার।

- *চাইল্ড* প্রকল্পে সার্বিক তথ্য ব্যবস্থাপনা ব্যবস্থার প্রয়োজনীয়তা পুনর্বিবেচনা করতে হবে যাতে তথ্যাদি আরো সহজ ও ভালোভাবে উপস্থাপনা করা যায়, যেমন সারণীর বদলে লেখচিত্রের ব্যবহার করা। অত্র মন্ত্রণালয়–এর সাথে তথ্য বিনিময় করার ওপর আরো জোর দেয়া উচিত আর তা যেন হয় আরো বেশী ব্যবহারোপযোগী ধরণের ছকে।

উপসংহার

স্বাস্থ্য ও পরিবারকল্যাণ মন্ত্রণালয় এবং একটি বেসরকারী সাহায্য সংস্থার (এনজিও) মধ্যকার অংশীদারীত্বের মূলনীতির দিক থেকে *চাইল্ড* তিনটি গুরুত্বপূর্ণ শিক্ষা নির্দেশ করছে।

- শিশুরক্ষা সেবাপ্রদান আরো কার্যকারীভাবে উন্নয়নের জন্য একটি কার্যকর পন্থা হলো, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়–এর সাথে মাঠ পর্যায়ে কাজ করা, বিশেষত: কম সফল অঞ্চলে।

- এনজিও কর্মকান্ডের মাধ্যমে টেকসই প্রাতিষ্ঠানিক ক্ষমতাবৃদ্ধির লক্ষে সহযোগিতা সম্ভব এবং তা কার্যকর হতে পারে, যদি তা সরকারী কর্মী বা তাদের কাজের বিকল্প হিসেবে না দাঁড়ায়।

- স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়–এর স্বাস্থ্য শাখা ও পরিবার কল্যাণ শাখার মধ্যকার পারস্পরিক সহযোগিতা সম্ভব এবং তাঁর ফলশ্রুতিতে উন্নততর সেবা প্রদান ঘটে ও স্বাস্থ্য এবং পরিবার পরিকল্পনা সেবা গণপর্যায়ে অধিকতর গ্রহণীয় করে।

1. INTRODUCTION AND BACKGROUND TO CHILD PROJECT

1.1 INTERVENTIONS

In October of 1991, as part of the Government of Bangladesh (GOB) initiative to improve the overall heath status of children under six and women of reproductive age, CARE began the Child Health Initiatives for Lasting Development (CHILD) Project in five of 11 thanas of Sylhet District. Funding for this Child Survival project was provided by USAID, CARE-USA, and the Australian High Commission. CHILD undertook to increase the availability of, and the demand for the following key maternal child services/interventions in Sylhet:

- Expanded Program on Immunizations (EPI),
- Control of Diarrheal Disease (CDD),
- Vitamin A Capsule Distribution (VAC), and
- Family Planning (FP).

In order to enhance the long-term sustainability, and therefore avoid dependency of progress on CHILD support interventions, direct services were not provided by CHILD in Sylhet. CHILD assisted the MOHFW mid-level managers and field workers, to strengthen, and to expand the outreach programs and develop community support for the use of basic health and family planning services. Thus, by working through counterparts, CHILD developed the capacity of the MOHFW to provide health and family planning services that will continue after CHILD.

1.2 OBJECTIVES

The specific objectives, as outlined in CHILD Detailed Implementation Plan (DIP), are:

1.2.1 Immunizations

- Increase the number of children, less than 1, who have been completely immunized from 6% to 50%,
- Reduce the drop-out rate to 10 % ,
- Increase the retention of maternal TT card to 50%,
- Increase the number of women aged 15-45 who have received complete tetanus toxoid (TT) immunizations to 50%,

1.2.2 Family Planning

- Increase to 20% the proportion of mothers using a contraceptive method among mothers who desire no more children in the next two years,

1.2.3 Diarrhea1 Disease

- Increase to 65% the percent of children, less than 24 months, with diarrhea in the last two weeks treated with oral rehydration therapy (ORT),

- Increase to 50% the percent of children, less than 24 months, with diarrhea in the last two weeks who were given the same amount or more of breast milk, food or fluids,

- Increase to 50% the percent of children, less than 24 months, with diarrhea in the last two weeks who were given the same amount or more of fluids,

- Increase to 30% the percent of children, less than 24 months, with diarrhea in the last two weeks who were given the same amount or more of food,

1.2.4 Vitamin A

- Increase to 50% the number of children aged O-72 months who receive vitamin A supplements during the last six months.

Baseline or annual surveys were conducted in 1991, 1992, 1994, 1995 to measure the progress towards the objectives of CHILD. These surveys have been used to evaluate the progress, and determine the effectiveness of CHILD over the last four years.

1.3 PROJECT LOCATION AND FUN-DING

In 1990, during the project planning, Sylhet was chosen as the project area because Sylhet was behind in all MOHFW National Programs, compared to divisional and national performance. For example, the national level of completely vaccinated children was 52% and the baseline survey of CHILD showed that coverage was only 6% in the five thanas of CHILD. The assistance of CARE was welcomed by the MOHFW at the National, Divisional and District levels for helping them to meet their national goals. Additionally, CARE had an established presence in Sylhet, from other CARE projects, and has the infrastructure needed to undertake the needed logistics support for the CHILD Project.

Initially, CARE received funding for one year (Child Survival VII) as a pilot project in five of the thanas of Sylhet District. Subsequently, CARE developed a proposal (Child Survival VIII) for three years of funding with a phasing into the other six thanas as part of a second phase of CHILD. The expansion phase of CHILD has not been possible due to a budgetary reduction, approximately 30% of requested funding, on the part of USAID PVO Child Survival Support Project to CARE. However, the funding that was received did allow CHILD to work in all of the interventions proposed.

1.4 CHILD STAFFING

The CHILD project employes 31 staff and is run primarily from the CARE sub-office in Sylhet Municipality (See organizational chart, Appendix E). Twenty are based at the project site, i.e. in the thanas, with all field workers resident in the thana headquarters town in which they work. Six senior staff are located in the CARE sub-office, Public Health Physician (PHP), Training Officer, Technical Officer, Project Officer and two Assistant Project Officers. Two senior staff are based in Dhaka, Project Coordinator and Assistant Project Coordinator.

All 20 basic field workers, now called Field Trainers (FT), are multi-purpose workers applying an integrated approach to service delivery and community mobilization. More than 50% of the FT staff are female. All FP work is done by female workers for cultural reasons, until now. There are some indications that it is becoming acceptable for males to do some FP work and in the future, CHILD plans to no longer have this type of division.

40% of CHILD staff previously worked for the TICA Project, an Immunization Project of CARE Bangladesh that recently ended. CHILD staff from TICA have brought both EPI technical knowledge and understanding of the MOHFW to CHILD. This experience and the original design, 35% focus on EPI, are directly relevant to the strong performance for the EPI and Vitamin A components of CHILD.

1.5 FINAL EVALUATION OF CHILD

The present phase of the CHILD Project will finish on August 31, 1995. Thus, this final evaluation encompasses the four years of the CHILD Project implementation in Sylhet since the beginning in 199 1.

2. OBJECTIVES AND METHODOLOGY OF THE EVALUATION

2.1 OBJECTIVES

2.1.1 Overall Purpose

The overall purpose of the evaluation was:

- To assess, document and disseminate the accomplishments, effectiveness and sustainability of the CHILD Project strategies and interventions (selected Child Survival Interventions),
- Especially looking at the partnership strategy with the MOHFW.
- Additionally, to make programmatic recommendations for the CHILD II Project, beginning in September 1995.

2.1.2 Expected Outcomes of the Evaluation

The expected outcomes of the evaluation were:

- To measure and document the major achievements of CHILD by comparing the achievements with the objectives outlined in the CHILD Detailed Implementation Plan (DIP).
- To assess how CHILD helped the MOHFW to achieve MOHFW goals/targets within the frame of the project.
- To assess the community's perceptions of the benefits of CHILD.
- Identify elements of the project's interventions sustainability at the community level.
- To identify, describe and analyze at which levels of the MOHFW system CHILD has been more effective in building capacity (strengthening institutions/improving skills).
- To make specific, realistic, programmatic recommendations for the future of CHILD II and CARE's health sector.
- To review and analyze which steps/actions the project undertook towards assuring the sustainability of the project achievements, especially as it relates to working in partnership with the MOHFW.
- Financial analysis of the CHILD Expenditures using CS VIII Guidelines.

2. METHODOLOGY

2.2.1 Team

The evaluation team was composed of the following members;

Mr. Robert Weierbach	Team Leader
Dr. Syed Reazur Rahman	National Consultant
Dr. Syed Umar Khyyam	Local Consultant (MOHFW)
Mr. Syed Md. Elias	Local Consultant (MOHFW)
Dr. Nizam U. Ahmed	CHILD Project Staff

Dr. Syed Umar Khyyam is the Deputy Civil Surgeon in Sylhet and Mr. Syed Md. Elias is Biswanath Thana Family Planning Officer. These two MOHFW staff from the project area were included in the evaluation team to ensure the participation of key counterparts of the project in this evaluation process. Due to other duties, they were unable to take leave for the entire period of the evaluation, but they committed much time and energy and in many cases, already possessed the local knowledge that the other team members needed to see first hand. This was critically important as the evaluation was also requested to look to the future and make suggestions for what the future agenda of CHILD II should be.

2.2.2 Process

An initial Team Planning Meeting (TPM) was held with the CHILD Project staff and the consultants on July 10 and 11, 1995 at the CARE staff house in Dhaka. The TPM allowed CHILD staff and consultants to come to an agreement on the roles, responsibilities and schedules of the evaluation team. Subsequent team meetings were held in Sylhet, at the beginning and end of data collection in the field. Finally, a team meeting was used to prepare the team for the final debriefing that took place in Dhaka on August 7, 1995.

The TPM was followed by document review, logistics arrangements and preparations, development of a methodology (Appendix C) and instruments for data collection (Appendix D) and observations in Sylhet. The methodology that was developed provided qualitative information from CHILD and Non-Child thanas. From July 17-27, the team was in Sylhet, (see Annex H: CHILD final evaluation schedule). July 25-26 were dedicated to bringing all the information collected to a list of major findings. July 27 was then dedicated to trying to bring together the results of the data collection and the expected outcomes of the evaluation by the entire team.

After the return to Dhaka, Mr. Weierbach and Dr. Rahman, the two full-time members of the team, continued to work together, and with CHILD staff, to provide CHILD with a document that would show the progress that had been made over the last four years and some suggestions that would build on the lessons of CHILD for the future of CHILD II, scheduled to start on September 1, 1995.

2.2.3 Dissemination

The findings of the evaluation were disseminated in two ways. The first was an external debriefing by the full evaluation team on August 7, 1995 to donors, MOHFW Officials from the National and District levels, **NGOs**, and CARE-Bangladesh staff. The second is this report which will be disseminated to all CHILD's partners and counterparts in the MOHFW. In order to facilitate the comprehension of this document, the Executive Summary has been translated into Bangla for easier comprehension of CHILD staff and counterparts.

2.2.4 Constraints

There were certain constraints and limitations to this evaluation. The first is that it was time limited and thus,the team could not visit all CHILD activities and field sites. Also, the review of CHILD documents, covering the four years of the project, was limited to key documents and documents that were able to clarify points about CHILD. Additionally, the field visit was planned so that it would give a representative look at CHILD and Non-CHILD areas, but should be viewed mainly as a qualitative assessment. Whenever possible, the team has used available data to backup their assessment. The April 1995 Knowledge and Practice survey conducted in the Non-CHILD areas of Sylhet was particularly useful for quantitative information. Thus, this report represents the views of the evaluation team and not those of any specific individuals. However, this is what was able to be determined in as fair and as unbiased a way as possible.

3. PROJECT ACCOMPLISHMENTS

3.1 OBJECTIVES OUTLINED IN DIP

Baseline or annual surveys were conducted in 1991, 1992, 1994, 1995. These surveys have been used to monitor the progress and determine the effectiveness of CHILD over the last four years. The specific progress toward the objectives, as outlined in CHILD Detailed Implementation Plan (DIP) are: (See Appendix A for the results of each survey for the different DIP objectives.)

3.1.1 Immunizations

Out of the four interventions, the greatest progress, over the last four years was made in the area of immunizations, which received the most attention. The results are presented in Table 1 and show considerable progress since 1991, the year of the baseline survey.

Table 1
EPI Objectives of CHILD

DIP Indicator	End of Project Objective	Baseline Survey 1991	Final Survey 1995	Non-CHILD Area Survey 1995
	%	%	%	%
Completely Vaccinated Child	50	6	54	16
DPTl to Measles Drop-out	10	52	22	43
TT Card Retention	50	12	31	13
TT Protection	50	10	26	8

- CHILD has dramatically increased the fully immunized coverage, for children from 12-23 months of age, from 6% in 1991 to 54% in 1995. This coverage is a crude rate, i.e. based only on card available data and there is no checking to see that immunizations were given at the correct time. Compared to the Non-CHILD area of Sylhet, which is only 16% in 1995, the work of CHILD is very impressive.

- The DPTl to Measles drop-out rate was reduced to 22%, from 52% in the 1991 baseline survey. In comparison to the Non-CHILD area, with a 43% drop-out rate, the progress is substantial. Additionally, the DPTl to DPT3 drop-out rate was reduced from 52% to 12%, in the CHILD area. Finally the recent national coverage survey showed that the DPTl to measles dropout rate was 18%, within the confidence interval of the CHILD survey.

- The retention of maternal cards was 31% in the final survey compared to 13% in the Non CHILD areas. This is a substantial improvement over the 1991 baseline of 12%.

- The survey, as it is currently designed, does not allow for measuring TT protection of all women 15-45 (the DIP indicator). However, among mothers with a child less than two, survey population, the 'IT coverage, two or more doses of TT, is 26%. This is only based on information on a vaccination card. When asked if they were vaccinated during their last pregnancy 63 % responded yes. 72 % , of those vaccinated, received at least two TT injections during their last pregnancy. Thus 26% is a very low estimate of percent of newborns protected against tetanus and most likely of mothers.

3.1.2 Family Planning

Family Planning is another area where CHILD was able to make substantial progress over the life of the project. Sylhet is still a very religiously conservative area although now, not as conservative as in 1991. Gains in FP have not been easy due to socio-cultural constraints.

Table 2
Family Planning Objective of CHILD

DIP Indicator	End of Project Objective	Baseline Survey 1991	Final Survey 1995	Non-CHILD Area Survey 1995
	%	%	%	%
Mothers who are users of FP	20	10	23	8

- Under CHILD, the proportion of mothers with a child less than two and desiring no more children for two years was increased to 23 % . This result is all the more dramatic when it is compared to the Non-CHILD area, which is only 8%.

3.1.3 Diarrhea1 Disease

CHILD began comparatively, to the other interventions, late in the area of diarrheal disease. Progress has been more difficult due to the nature of the intervention and to delays at the national level in developing community based educational materials. CHILD did not develop any of their own educational materials in CDD.

Table 3
CDD Objectives of CHILD

DIP Indicator	End of Project Objective	Baseline Survey 1991	Final Survey 1995	Non-CHILD Area Survey 1995
	%	%	%	%
Diarrhea cases using ORT	65	39	54	40
Diarrhea cases receiving more or same amount of breast milk	50	56	48	46
Diarrhea cases receiving more or same amount of fluid	50	37	50	35
Diarrhea cases receiving more or same amount of food	30	13	10	10

- The use of ORT for children under two with diarrhea, that occurred in the last two weeks preceding the survey, increased from 39% in the baseline survey to 54% in the final survey.
- In the final survey, 48% of children being breast feed were given more or the same amount of breast milk.
- 50% of diarrhea cases, in the final survey, were given more or the same amount of fluids.
- 10% of children with diarrhea, and not breast feed, were given more food during the episode.

The progress of CHILD, in the area of CDD DIP objectives is mixed and is reflective of the slow start that CDD activities had in CHILD. The progress in the use of ORT, from 39% to 54% is encouraging and shows progress toward the original objective of 65 %. Within the category of ORT use, 61% of cases used ORS packets to provide oral rehydration therapy. The lack of progress in feeding practices during diarrhea is an area of possible concentration in the future. These practices are difficult to change and require much more time and an educational effort than say that for the mobilization of the community for EPI.

3.1.4 Distribution of Vitamin A Capsules

This is another area where the CHILD Project has made tremendous progress since 1991.

Table 4
Vitamin A Objective of CHILD

DIP Indicator	End of Project Objective	Baseline Survey 1991	Final Survey 1995	Non-CHILD Area Survey 1995
	%	%	%	%
Children who received VAC within 6 months	50	16	74	44

- In the final survey, 74% of children less than two received Vitamin A within the past six months. This indicator has progressed well beyond the objective set out in the original DIP, 50%. The result when compared to the Non-CHILD area is all the more impressive.

- The VAC coverage in CHILD thanas, reported by the MOHFW, for children l-5 years of age, the target population for VAC in the April 16, 1995 National Immunization Day, is 88 % . Thus even though this indicator was not measured directly by the K&P survey, there is strong evidence, via the routine monitoring system, to suggest that it was reached.

3.1.5 Limitations of Survey Findings

The K&P survey has been very useful in providing consistent information over time to measure the progress of CHILD from 1991 to 1995. However, the evaluation team observed that this tool has limitations for a project not providing direct services like CHILD. The survey design is not able to measure all the objectives and in some cases, objectives have been modified to fit the standard survey format. This has resulted in a FP indicator that is not able to be compared to any other available data in Bangladesh. Comparison of data with other surveys is expected by the MOHFW, and CHILD needs to know where they are in relation to the Divisional and National Levels. The survey design and tailoring of indicators is creating problems for CHILD at the National Level, particularly EPI, as the results are not consistent with other sources of information from the MOHFW, which themselves have limitations.

The CDD data has shown considerable variation over all of the surveys, see Table 5, and can be seen in the results for different CDD Feeding Indicators, over all of the surveys. This is probably related to the way that the questions are asked in their current formats. The National CDD program indicated that in their experience, this could be related to the way that questions were asked and the difficulty of getting reliable information on feeding during episodes of d i a r r h e a .

Table 5
CDD Feeding Indicators

DIP Indicator	Baseline Survey 10191	Follow-Up Survey 11/92	Mid-Term Survey 2/94	Final Survey 4/95
	%	%	%	%
Same or more breast-milk	56	35	70	48
Same or more fluids	37	23	34	50

Additionally the number of diarrhea cases has declined to 48 in the current survey, see Table 6. The K&P survey needs to be done at a time of the year that will give the maximum number of cases. The baseline survey was done in October and had the highest incidence of diarrhea (July to October is the height of the diarrhea season in Bangladesh).

Table 6
Number of Diarrhea Cases in K&P Survey

	Baseline 10/91	Follow-Up 11/92	Mid-Term 2/94	Final 4/95
Diarrhea Cases	89	69	53	48

Bangladesh conducts National EPI Coverage Surveys, with Divisional breakdowns, on almost a yearly basis. CHILD's methodology and analysis (children 12-23 months and only with card available data) is creating confusion with the National EPI Program Managers. With some additional effort, CHILD could collect vaccination information from 210 children in the 12-23 month age group and then compare the results with the rest of Bangladesh. Additionally, analysis of vaccination coverage data in COSAS would allow for some measurement of quality indicators. (This is planned for the CHILD final survey and CHILD II baseline.) For example, of the measles vaccinations given, 18% were given before the age of 9 months, GOB policy for measles immunization, according to the final survey.

Additionally, TT coverage was not measured for all women 15-45, but only for those women with a child less than two. The objective could be reformulated so that it talks about protected births in the last two years. It is important to consider the history, by the mother, of TT vaccinations as they have been shown to be reliable. Thus, a careful history of the total number of TT doses received would show that many more mothers and births are protected and be a better evaluation of the progress of CHILD.

The K&P Survey also has a bias in that it excludes children who have died in the last two years, and their mothers, from the sample. This means that "high risk" mothers and children are excluded from the sample. Children who have died can not be in the sampling frame but their mothers need to be as their future children are the most at risk. This could be accomplished by taking 210 women from 15-45 years of age, without regard to their having a child, for measuring 'IT coverage and contraceptive prevalence.

Operationally this could be accomplished by using the same 30 clusters for the 300 mothers, 12 to 23 month old children and for women 15-45 years of age. The feasibility of this approach and the importance of collecting the information, primarily for better understanding of CHILD accomplishments by national counterparts, should be considered for the next survey that is done.

3.2 COMMUNITY PERCEPTION OF BENEFITS

Probing of the community, by the evaluation team, demonstrated that there was a recognition that services are now more regular. In comparison with other communities, outside of the CHILD area, services were observed to be less regular by the evaluation team.

The community had no clear identification of a benefit from "CHILD" alone. This is easily explained by the fact that CHILD workers are seen as "coming from the Thana Hospital", just like all of the other workers who are providing services to the community. In the opinion of the evaluation team, this shows that CHILD has well integrated itself into, and working with the overall system of the MOHFW.

Additionally, in the CHILD area there was more of a commitment on the part of the community to support the health and family planning services supported by the CHILD Project. While this is difficult to dissociate from community values, community service and self-responsibility, there was much more of an interaction with the community observed at the outreach and satellite sites visited in the CHILD area.

Finally, it was mentioned by one mother that some of the CHILD field workers, who are very visible because of their motorcycles, are being help up as role models as to the potential that their children, in this case a female child, have for the future. Thus while CHILD is not known directly to the community, there were a number of direct and indirect positive impacts that CHILD had on the community

3.3 OTHER ACHIEVEMENTS

- Health Worker Motivation

  CHILD has helped to develop the skills of MOHFW workers, in the field and at the supervisory level, resulting in more confident and skilled workers. Services are now more regular in the CHILD areas, compared to Non-CHILD area. Health workers have truly learned and become empowered to provide better services (more regular and of improved quality). At the District level, the EPI Supervisor expressed that he thought that the MOHFW staff in the CHILD areas was better motivated.

- Development of Problem Solving Skills

  CHILD staff have helped to develop the problem solving skills of their various counterparts. This was particularly evident in how MOHFW monthly meetings are now effectively dealing with how to improve the system of service delivery.

  This is best illustrated by the problem of vaccination sessions not being held because the assigned vaccine porters were not always available. The solution that was arrived at, was that there would be no assigned porter but whoever was available would be the porter for that day.

- Community Mobilization

  The benefit of the CHILD is not directly perceived by the community because of the partnership strategy. But it has been admitted by many of the front-line workers that the CHILD FTs are well accepted by the community and they are better community mobilizers and motivators. The improvement of the regularity and quality of services are well recognized. Increased activity of H&FP front-line workers and improved relationship with the community are also felt by the beneficiaries.

- Effective Integration of Outreach and Satellite Services

  Within the CHILD areas, there was a real integration of Outreach and Satellite services that was not seen by the evaluation team in the Non-CHILD areas. This was particularly striking beginning in January 1995. Figure 2 clearly shows how this integration has proceeded over the life to the CHILD Project.

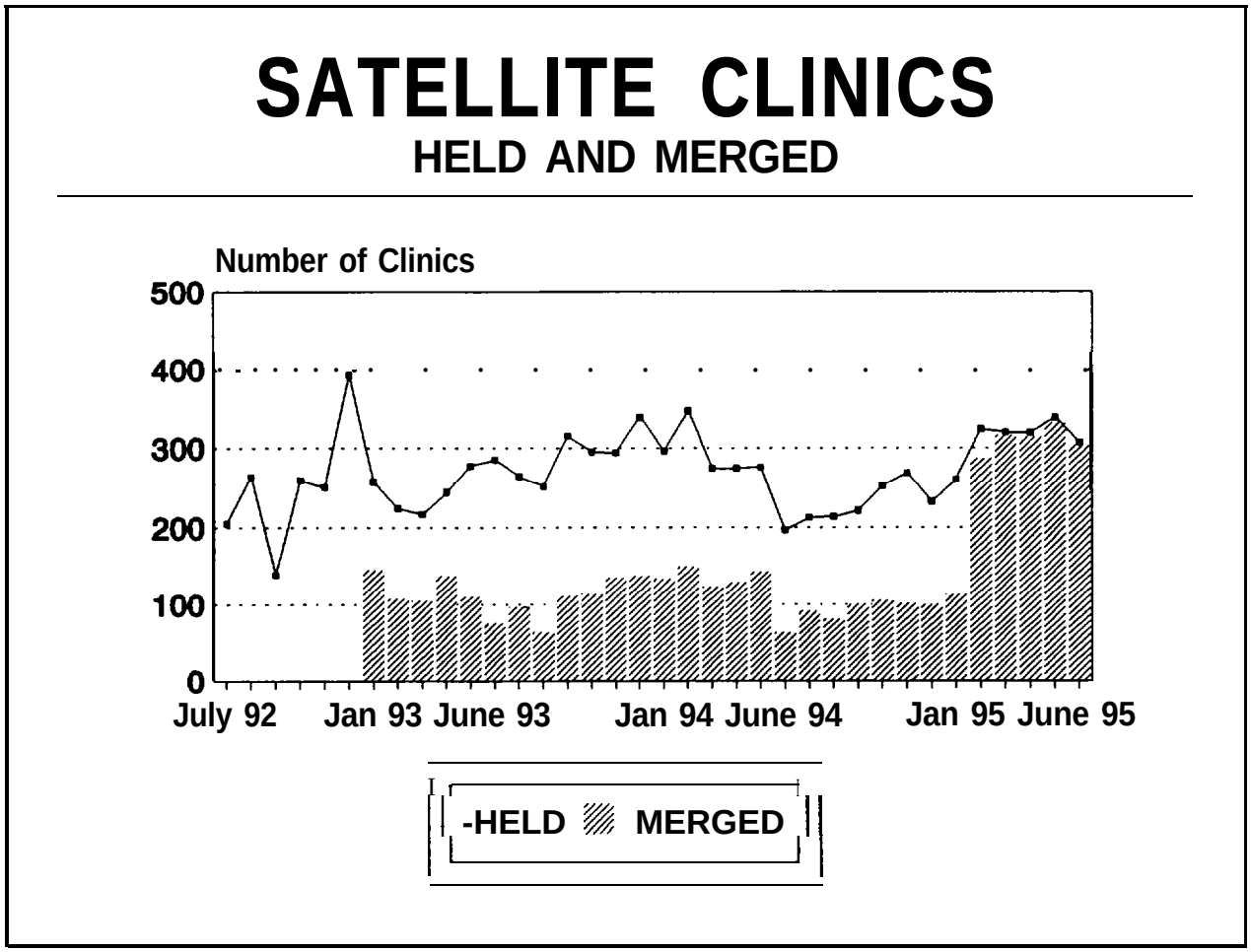


Figure 2

- Targeting of Hieh Risk or Undeserved Ponulations

A specific program for tea garden workers illustrates how CHILD was a "Catalyst" in making something happen. The program was developed by bringing together the MOHFW in Sylhet and the management of the tea gardens to allow for vaccination of children and obtaining of FP services by mothers. At the same time, the system would have a minimal impact on the production of the tea gardens, so that the workers would not be penalized for being absent from work. This was accomplished by offering services at a time, during the early morning break, when the tea workers were most likely to be able to attend, even though it was earlier than services are normally provided by the MOHFW. Managers of the tea gardens, agreed not to dock workers for extra time absent, as long as they were seeking services.

- Achievements Outside of CHILD Area

  The evaluation team, during visits to Non-CHILD areas, found that some of the tools developed by CHILD were being used by MOHFW staff that had been transferred to Non-CHILD areas. In the case of a TFPO, the tools developed by CHILD, (HIS Form 3/satellite clinic checklist in particular) were being used to improve satellite clinic services in his new area.

4. INSTITUTIONAL CAPACITY BUILDING

4.1 GOB AND PUBLIC REPRESENTATIVES

CHILD Project staff have helped the MOHFW staffs to:

- Effectively Integrate Satellite Clinics:

  In the CHILD areas Satellite Clinics (SC) have been effectively integrated in a systematic manner. In 1995, more than 90% of the SC are integrated compared to reported 20-30% in the Non-CHILD areas. The evaluation team found very low levels of integration in the Non-CHILD areas. In those, with a reported integration there was no clear understanding of what integration means for the SC operation.

- Develop Control Rooms for Monitoring of Activities:

  In the **CHILD** area, these rooms are being used as a center for the monitoring of coverage for EPI and FP. Graphical presentations of the coverage were observed to be routinely done by thana-based staff. In Non-CHILD areas, there was no control room or there was no evidence of routine monitoring of coverage information.

- Ensure Appropriate Planning of Activities:

  The Outreach Sites and Satellite Clinics were scheduled for a period of three/six months in the CHILD areas. Field visits to these sites were easily accomplished because of the clear and understandable format that was used. In one of the Non-CHILD thanas, the EPI Technician told the team that he no longer does the three monthly schedule because it is not followed.

- Conduct Regular Community Visits:

  Through the field visits with FWAs and FWVs CHILD staff have helped to improve the community visits. The improved FWA Register in the CHILD area were mentioned several times as something that CHILD had provided assistance to the FWA.

- Convey Health Messages to Mothers:

  FWAs and FWVs routinely mentioned the skills of CHILD staff in mobilizing and communicating with the community. The on-site training that is done by CHILD during community visits and in outreach sites and SCs was mentioned as being very useful by the workers themselves. FWAs and FWVs expressed that they had learned by observing the CHILD staff and gained training and confidence in their work.

4.2 RESPOND TO SPECIFIC REQUIREMENTS

- Tea Gardens

  The project has catalyzed the effort by the MOHFW to provide services to the tea garden workers (originally immigrant workers from India) in several tea gardens within the project thanas. This population has required the need for an adapted approach as they are not normally able to come for services at the times that they are routinely provided by the MOHFW.The program was developed by bringing together the MOHFW managers in Sylhet and the management of the tea gardens to allow for vaccination of children and obtaining of FP services by mothers. The result was services being provided at a time that was convenient to both the mothers and the management.

  This demonstrates an attention to the needs of hard to reach populations and the adaption of the service delivery system to meet the unique needs of a group of clients.

- National Immunization Day

  National Immunization Days (NID) and Maternal and Child Health Fortnight were repeatedly mentioned as occasions when CHILD was especially useful in assisting their MOHFW counterparts with planning and implementation. Sylhet District in fact was cited for the particularly good performance that it was able to achieve. Since Sylhet is usually considered to be one of the areas of the country behind in national programs, it is especially significant that Sylhet did so well during these two national campaigns. In the opinion of the MOHFW, CHILD contributed to this success and more importantly was greatly appreciated by the MOHFW.

  While the eradication of poliomyelitis is not one of the objectives of CHILD, support to the MOHFW in meeting the challenge to this international goal was important. The flexibility shown by CHILD in supporting NID and MCH Fortnight were very appropriate deviations from the long-term agenda of developing the routine immunization program .

5. SUSTAINABILITY ELEMENTS

5.1 CHILD PROJECT STEPS TOWARD SUSTAINABILITY

The CHILD Project has taken into consideration the issue of sustainability from the beginning of the design of CHILD. This attention to sustainability from day one has helped to assure, to the maximum extend possible, the long-term sustainability of the interventions. Later, after the Mid-Term Evaluation, there was a specific plan developed by CHILD for project sustainability.

Thus, only technical assistance, and no funding for discreet activities within the MOHFW is provided by CHILD which does not provide direct services. This has helped to make the expectations of the various partners realistic as they realize that the field staff do not control any funds.

Therefore, CHILD has worked to strengthen what already exists and try to improve the performance and the efficiency of the MOHFW system. This approach has many external factors that can effect it, such as vacant posts and lack of MOHFW funding, but is a realistic project approach to trying to build a sustainable system.

5.2 COMMUNITY LEVEL

There were clear indications that in Sylhet, still a very religiously conservative area of Bangladesh, there are some important sociological changes going on. This is best illustrated by the visit to an EPI outreach site where the evaluation team talked to the household owner. There were four children in the household and the two oldest boys had never been to school. The third child, a boy, was currently attending school and the fourth child, a girl, was also attending school. This move to educating the children will bring about even more change in the future.

Health and FP workers are now much more accepted in the community. During the early stages of FP in Sylhet there was physical harassment of FP workers by the population. It was not considered to be appropriate for a women to walk around the village, much less talk to women about family planning. This has also changed and the FWVs and FWAs are now readily accepted as doing their job in the community.

There is however still some reluctance, regarding Family Planning use, within the community. For example, the team heard stories of religious leaders who have requested FP services for their wives but asked that their request be kept confidential. Thus, while there is increasing acceptance of services, there is a strong reluctance to be public about the use of FP in Sylhet.

It is difficult to attribute some of these social changes observed to CHILD alone, but the project has helped the front-line Health and FP workers to provide regular and reliable (quality) services. This change has ensured that even the conservative rural women come out and seek these services in the interest of health of their family members.

Increasing the mobility of women in Sylhet is well marked, particularly during the last three-four years. But the ***purdah*** system, which specifies restricted movement of women, is still strong.

Mothers going to public places or to other peoples' houses is increasingly acceptable in the interest of children. Thus in merged satellite clinics, EPI services are providing a cover for some women to get information on FP and/or FP services. Some of the women interviewed expressed that they still needed to have in-home services.

There is increased communication with male health workers and indeed, with outside males who are considered to be potential service providers. This has brought about a definite acceptance that males have a role in the provision of FP services.

The project contributed to community women feeling more confident in interacting with the public and with outside males. During the evaluation, the team was accompanied by a female CHILD worker for the community interviews but, at no time was it a problem asking women, without their husband present, about health and family planning services in their homes. According to one TFPO, this would have been unheard of just a few years ago.

The changing norms regarding community women seeking health services are achievements that will be sustainable even if the project were to end. The dynamic of women's mobility has a strong demonstrative effect. There are women who are reticent to go to the health service centers will probably eventually be persuaded to go to the health service centers just by observing other women doing so.

5.3 MINISTRY OF HEALTH AND FAMILY WELFARE

The most obvious example of how sustainable CHILD results are within the MOHFW is the conversation that the evaluation team had with the EPI Supervisor in Sylhet. He had found that in the CHILD area, the EPI Technicians, responsible for EPI at the thana level, were more motivated. The evaluation team was told, in the CHILD thanas, how they were satisfied with the CHILD project. They also expressed that they had directly benefitted from the training and that there work was better organized. They were confident in their ability to do the work and were of the opinion that they would be able to continue their higher level of performance on their own after CHILD. In the non-CHILD thanas, the EPI Technicians expressed that they were overwhelmed with the work that they needed to do. To the evaluation team there is a definite sustainable capacity that has been built at the level of the EPI Technician.

At other levels, the team have heard that people have seen, from CHILD workers how the community can be motivated. This is a skill that they have learned and are using. Primarily, this was expressed by HAs, FWAs and FWVs. Ideally, the increased contact with the community will increase involvement and assure sustainability in the long-term. The effect of CHILD seems to have been that now, MOHFW field staff are better skilled workers, providing more regular and better quality services to the community.

Additionally, monthly meetings that are part of the MOHFW system were also improved in a positive and sustainable way. The meetings are now better attended, more regular and deal with more than administrative matters.

The work that CHILD has helped with in the Tea Gardens of Sylhet will continue as there is a commitment between the managers of the Tea Gardens and the MOHFW for the program.

6. LESSONS LEARNED

6.1 CHILD PROJECT STRATEGY

- The strategy of CHILD has had a very positive impact on performance and motivation of health workers. This is particularly evident at the level of the workers who interacts with the community in the outreach and satellite sessions. Once again, it needs to be mentioned that this was done without providing extras (funding, perks etc.) to the worker or the system in which they work.

- Focusing the training and technical support at the THC level and below has worked. Training that was done in the field by CHILD staff was effective. This has allowed for workers to be trained in an effective manner but also allowed for CHILD to be part of the system for addressing the system barriers to doing their work.

- There is a need to have a mutually agreed vision, on the work of the project, with all levels of partners. This has not always been possible and is best illustrated by the lack of understanding on the part to the TFPOs about what an FT is a trainer of in FP.

- Targeting the MOHFW positions that are stable, i.e. not transferred frequently, has also contributed to the success of the nroiect. While there were also instances where transfers of managers had occurred, forms and techniques, developed in CHILD areas, were being used without CHILD help.

- EPI impact appears to be sustainable, assuming a ready supply of EPI commodities, and has resulted in workers being more confident in their jobs and better motivated.

6.2 CHILD PROJECT STAFFING

- Mobility of the CHILD field staff was a maior contribution to their effectiveness.

- The former TICA staff contributed to the effectiveness of the EPI intervention as they were well experienced with EPI and the MOHFW.

- There needs to be clarity, within project staff and outside, about counterparts and roles.

6.3 MINISTRY OF HEALTH AND FAMILY WELFARE

- There needs to be more clarity about who counterparts are and their roles.

- Understanding and being responsive to the needs of the partners/counterparts has resulted in assistance that has made a difference and contributed to the success of CHILD.

- HIS and supervision tools, need to be the same for partners and nroiect staff. Additionally the information collected needs to be shared between the different parties.

- Priority needs to be given to the program of counterparts, i.e. MOHFW. This was generally done by CHILD beyond the project objectives (for example: the project support to NID).

- MOHFW wines can work together, at least in the field. CHILD has been very effective in bringing MOHFW wings together and helping them jointly plan for implementing services. Examples are the CHILD thanas and the regular quality services that are being provided.

6.4 COMMUNITY

- Within the communities of Bangladesh there is a sense of community responsibility that can be used and rewarded. The program initiated by CHILD, for rewarding the community participants, in NID and MCH Fortnight is a good example of how this can be done.

- The overall social changes in society within Bangladesh, even in a conservative area such as Sylhet, is allowine for progress. The project has been very sensitive to the cultural appropriateness of what their field staff are doing. Early on, only women were involved in FP work, but now there are also men doing FP work. However, CHILD has also been ahead of some of the norms, 50% of field staff are women and have motorcycles, in a very positive way.

7. RECOMMENDATIONS

7.1 EXPANSION OF CHILD

- CHILD II needs to expand from the present 5 thanas to include the remaining 6 thanas of Sylhet District.

  The expansion needs to be in a phased manner, for example every six months start in two new thanas, that will allow for some continuing activities in the current CHILD thanas and allow time for the proper development of a plan for CHILD II work in the new thanas.

  Location of, and work in the new thanas will need to be prioritized so that appropriate logistics and technical assistance can be provided within the scope and budget of, CHILD II.

  Involvement of Sylhet District MOHFW in the phasing in, and choice of priorities will help to increase the ownership and knowledge about CHILD II. Participation of THFPO and TFPO in the thana activity planning will clarify the role of the THC staff and who their counterparts are.

- CHILD II should have as a focus, the increased utilization of, and improved quality of services at outreach and satellite sites in the 6 new thanas.

  The work of CHILD has clearly resulted in improved access, i.e. more regular services, and better utilization, i.e. increased vaccination coverage, in the five thanas of CHILD. There is a real need for this type of service improvement in the six new thanas of CHILD II.

  CHILD has also developed an instrument, HIS Form 3, that is a way to monitor quality of outreach and satellite services. Currently, this tool is only used by CHILD staff, and perceived as a CARE tool by THFPOs and TFPOs. However this data is not routinely shared with staff that the THC level. Broader consensus on the content of, and use of HIS Form 3 needs to be done. Attention also needs to be focused on ways and presentations of the analysis of the information from HIS Form 3 at the Thana level.

- The community mobilization and participation that has been accomplished in the original 5 thanas should develop in the new thanas of CHILD II.

  This is an area where CHILD has repeatedly showed MOHFW staff how to accomplish community based work. The hands-on approach has worked well and needs to be an integral part of the work in CHILD Il.

  This assistance in the original five thanas should be phased out in the existing CHILD thanas. This will allow current staff to begin these activities in the new thanas.

7.2 EXPANDED PROGRAM ON *IMMUNIZATIONS*

- Future EPI work should include disease control and surveillance activities.

Since January 1994, the Weekly Epidemiology Report (WER) of Institute for Epidemiological Disease Control Research (IEDCR) is collecting information on EPI diseases. This is a community-based system and needs to be added to the monitoring activities for EPI. Initially, disease control activities will need to be done in the existing five thanas and the experience gained used in the 6 new thanas at a later date.

- CHILD should develop the use of manning techniaues at the THC level.

Detailed maps are available, from Survey Bangladesh in Dhaka, for the different thanas (Police Station Map and Mouza (Village} Map) and should be used to visualize all of the service points, outreach and satellite. This will allow for more realistic planning of services and allow FP to know where outreach sites are and health to know where satellite sites are. It was the experience of the evaluation team that there is overlap of outreach sites with outreach sites and with satellite sites.

Mapping will also be important for the disease surveillance activities of EPI.

7.3 CONTROL OF DIARRHEAL DISEASE

- Health Education activities need to be better targeted and multiple approaches continued to be developed.

In the area of CDD, there is a need to make sure that the message about feeding and fluids during diarrhea is understood by the community. The Final Survey showed that 75% of mothers still believe that feeding should be stopped during episodes of diarrhea. In the future, special attention should be placed on this aspect.

CHILD has initiated the Participatory Approach to Adult Learning (PAL) approach and a Child to Child activity as ways of better reaching the population for educational purposes. These need to continue and be improved. In particular, special hard to reach populations need to have adaptations to current education activities to make them relevant. A good example is the special language requirements of the tea garden workers.

- The Child-to-Child work, begun under CHILD, needs to obtain technical input from the Sylhet based CDD Coordinator and identify an appropriate counterpart to work with on the development of the specific materials from CHILD.

The work that has been done in Child to Child is encouraging and represents a new and different approach to educating the community not only about treatment of diarrhea but also how to prevent diarrhea. The message on diarrhea treatment needs to be simplified and attention should be paid to not overload the number of messages presented.

Special attention needs to be paid as to how this work will be sustained. Currently, a CHILD staff facilitator is required and expecting MOHFW field workers to undertake these sessions may not be possible.

7.4 FAMILY PLANNING

- CHILD II should explore how to use the traditional birth attendants to increase the use of services as well as educate the community.

  During the visit of the team, it was expressed several times that there is a need to integrate this community resource, TBAs, into the national FP program. In some CHILD areas, the team observed TBAs bringing mothers to the satellite clinics. A systematic approach that was well documented would be extremely useful to the MOHFW, for use outside of CHILD areas.

- As part of the expansion, focus assistance in FP on the merged satellite ouerations.

  Merged satellite clinics have become a reality under CHILD, particularly since January of 1995. Providers and users were uniformly of the opinion that services were better and more regular under the system of merged satellite clinics. This CHILD accomplishment is particularly impressive given the situation with health and family planning in Bangladesh. Assistance would help be to make sites more regular and provide quality integrated services in CHILD-II areas.

7.5 PROJECT MANAGEMENT

- CHILD II needs to review the current supervisory structure of the nroiect. There needs to be more direct leadership/supervision of thana teams and more interaction with the TFPO and THFPO.

  There is considerable confusion at the THFPO and TFPO level as to who is "in charge" of the CHILD Thana-based team. This can be alleviated by carefully planning with the THFPO and TFPO for the new thanas so that there are clear lines of communication and clear expectations.

  The CHILD Team at the Thana level is considered a group of equals. But, in reality there are individuals who assert themselves as the leader. There should be a team leader and that individual could be the APO.

- The current CHILD HIS needs to be reviewed to make it a better monitorine tool for CHILD II.

  There needs to be graphical, as opposed to tabular presentations that currently are used, presentations to allow for analysis over time. Additionally, information needs to be shared with the MOHFW according to the needs of the different managers.

  There is a considerable amount of information that is collected by the MOHFW, particularly FP and EPI, that could be more effectively used to monitor CHILD II. This information is currently collected and passed on, on a monthly basis, to Dhaka but not used by the Project Manager to monitor CHILD.

  The CHILD HIS Form 3 needs to be used by more than CHILD Staff so that the information is more representative of what is going on in the Thana. Detailed analysis of this form should be done at the thana level and CHILD needs to extract the information that it needs to report on, and monitor CHILD.

  Current information is only displayed in a tabular form and on a monthly basis. Consideration should be given to making the reporting graphical and cumulative for the year with the data bases being provided, as needed, to Dhaka.

- CHILD needs to prepare documentation on lessons that it has learned so that they can be more easily shared with the MOHFW and other NGOs. Additionally opportunities need to be identified, or created, to present the lessons of CHILD to others within Bangladesh. There are three topics that need to be done as a priority:

  * Experience in Tea Gardens,
  * Child-to-Child Work, and
  * Quality of service Improvement (HIS Form 3).

8. CONCLUSION

CHILD has demonstrated three important achievements in terms of a partnership strategy between a NGO and the MOHFW:

- Working with the MOHFW at the field level is an effective way of improving child survival services, particularly in low performing areas.

- Collaboration for sustained institutional strengthening is possible and effective as long as the NGO inputs are not substituting for GOB workers and responsibilities.

- Stronger coordination and collaboration, between the "wings" of the MOHFW, is possible and results in improved service delivery and better community acceptance of health and family planning services.

9. FINANCIAL REPORT OF CHILD EXPENDITURES

The total agreement budget for CHILD, under CS VIII, (l/9/92 to 31/8/95) is $1,040,740, including $680,000 provided by USAID and $360,740 by CARE. When starting this project in September 1992, there was an initial budget deficit of approximately 30%. Accordingly, the project team significantly revised plan in order to reduce their costs. For example, external consultants were not hired for the K&P surveys in 1992 and 1994, reducing overseas training opportunities, and carefully monitoring procurement and logistics supplies. In addition, other shared cost at the CARE Bangladesh mission level has been less than initially planned, and relevant line items expenditures were reduced (expatriate personnel, consultancies for evaluation and surveys). This thorough financial management of the project contributes to reduce operational costs over the last three years. In FY-95, CARE receives additional funding from the Australian High Commission (AHC) for a amount of US$ 37,012, which allows the project to run more smoothly in the last year of implementation of project activities.

At the date of this evaluation report (June 30, 1995), the project expenditures trend analysis shows that on average, $ 22,000 per month were required for routine operation of the project. However, additional expenses are expected for the last 2-3 months of the projects including cost for the final evaluation, phase-out activities, closer first phase of the project (workshop with counterparts, report dissemination), and start-up activities for the next phase.

Appendix G contains a detailed pipeline report, according to the guidelines of BHR/PVC (CS-VIII), for the CHILD cost of CARE Bangladesh. The information needed to complete Forms A and C is not available in Bangladesh and will be provided separately.

LIST OF APPENDIXES

APPENDIX A: PROJECT INDICATORS, TARGETS, AND ACHIEVEMENTS

INDICATOR			Baseline Survey 10/91	Annual survey 11/92	Mid-term Survey 2/94	Final Survey 4/95	Project Target
EPI	Increase to 50% (card) the number of children 12-23 months fully immunized.		6%	26%	35%	54%	50%
	Reduce the dropout rate to 10%.	OPV I-3	46%	28%	20%	17%	10%
		DPTI-3	52%	25%	20%	12%	
		DPTl-M	52%	30%	14%	22%	
	Increase the retention of maternal TT card to 50%.		12%	20%	16%	31%	50%
	Increase to 50% (card) the number of women aged 1545 years who were protected during their last pregnancy	TT1	3%	6%	3%	15%	50%
		TT2/TT2+	10%	15%	14%	26%	
FP	Increase to 20% the proportion of mothers using a contraceptive method among mothers who desire no more children in the two next years.		10%	16%	22%	23%	20%
CDD	Increase to 65% the percent of children less thon 24 months with diarrhea in the past two weeks, who were treated with ORT.		39%	45%	36%	54%	65%
	Increase to 50% the percent of children less than 24 months with diarrhea in past two weeks, who were given the same amount or more breast-milk.		56%	35%	70%	48%	50%
	Increase to 50% the percent of children less than 24 months with diarrhea in past two weeks, who were given the same amount or more fluids.		37%	23%	34%	50%	50%
	Increase to 30% the percent of children less than 24 months with diarrhea in past two weeks, who were given the same amount or more food.		13%	13%	11%	10%	30%
VIT A	Increase to 50% the number of children aged 0-72 months who receive Vitamin A supplements during the last six months.	Total	16%	35%	51%	74%	50%
		0-11	N/A	22%	41%	70%	
		12-23	N I A	52%	65%	89%	
	Total sample size of surveys and percentage and number of children in two age groups	Total	311	302	302	300	
		O-11 mos.	63.3 (n=197)	57.9 (n=175)	57.9 (n=175)	61.O (n= 183)	
		12-23 mos.	36.7 (n=114)	42.5 (n = 127)	42.1 (n= 127)	39.0 (n=117)	

APPENDIX B: KEY CONTACTS

I National Level

Ministry of Health and Family Welfare, Government of Bangladesh
Dr. Samsul Haque, Project Director-EPI, EPI HQ, Dhaka.
Dr. S. M. Asib Nasim, Project Director-Control of Diarrheal Disease Program

CARE Headquarter, Dhaka
Dr. Florence Durandin, Health and Population Sector Coordinator (previously Project Coordinator, CHILD)
Dr. Nizam Uddin Ahmed, Acting Project Coordinator, CHILD project.

USAID/Bangladesh
Mr. Robert Cunnane, Chief NGO unit

Australian High Commission
Ms. Roushan Akhter, Senior Development Officer

World vision Bangladesh
Dr. Ratu Gopal Saha, National Health Coordinator
Mr. Sylvester S. Costa, Project Director-Dhaka Urban Integrated Child Survival Project
Dr. Prodosh Kumar Roy, Program Manager-Dhaka Urban Integrated Child Survival Project
Dr. Sri Chander, World Vision International-Regional Health Advisor

Save The Children (USA)
Dr. Afzal Hossain, Senior Project Officer
Dr. Najma Khatun, Senior Medical Officer

II District Level, Sylhet District

Ministry of Health and Family Welfare, Government of Bangladesh
Dr. G.M. Mahmood, Civil Surgeon (CS)
Mr. Gowranga Chandra Chakrabarti, Deputy Director FP
Dr. Shirin Chowdhury, AD-FP (Clinical Contraceptive)
Dr. Umar Khyyum, Deputy **CS, Team Member of Evaluation**
Dr. Nazmul Haque, Medical Officer, CS
Dr. Md. Tarek Azad, Coordinator, Diarrhoeal Disease Cell
Mr. M. A. Rouf, EPI- Supervisor
Mr. Saleh Ahmed Chowdhury, Junior Health Education Officer
Ms. Begum Shathi Chowdhury, Public Health Nurse

Sylhet District Sub-Office CARE
Mr. Musharrof Hossain, Administrator, Sub-Office

CHILD Project Office, Sylhet
Dr. Zia-ur-Rahman, Project Manager (Public Health Physician)
Mr. Bakaul Islam, Training Officer
Mr. Shameem ud Dawla, Technical Officer

Mr. Subrata Kumar Dey, Project Officer
Ms. Nasima Khan, Assistant Project Officer
Mr. Dukul K. Barua, Assistant Project Officer

III Thana Level, **Sylhet District** (MOHFW officials)

Sylhet Sadar Thana
Dr. Rafiqul Islam, THFPO
Mr. Ahmed Kabir Haidary, TFPO
Dr. **Anup** Chowdhury, Medical Officer, EPI

Biswanath Thana
Dr. Foyez Ahmed, THFPO
Mr. **Sayed** Md. **Elias,** TFPO, **Team Member of Evaluation**
Dr. Anwarul Islam, Medical Officer-EPI
Mr. Md. Abul Kalam, ATFPO
Ms. Rahela **Begum,** Senior Family Welfare Visitor (Sr. FWV)
Mr. **Sirajul** Islam, EPI-Technician

Balaganj Thana
Dr. B. K. **Banik,** THFPO
Dr. Abdus **Salam,** MO, EPI
Ms. Saibalini Ray, FWV
Mr. Satendra Biswas, EPI-Technician

Kanuighat Thana
Dr. Foyez Ahmed, THFPO
Mr. Dhirendra Debnath, EPI-Technician
Ms. **Usha Rani,** FWV

Beanibazar Thana
Dr. Mahmudur Rahman Khan, THFPO
Mr. Mohibur Rahman, TFPO
Dr. Sajibur Rahman, MO-EPI
Ms. **Asma Begum,** FWV
Mr. Sunil C. Das, Assistant Health Inspector (AHI)

Other Thanas
Dr. Md. Abul **Hasem,** THFPO, Companiganj **Thana**
Dr. Md. Nurul Islam Chowdhury, THFPO, Fenchuganj **Thana**
Mr. Mohibur Rahman, TFPO, Fenchuganj **Thana**

I v Thana Level, Sunamganj District (MOHFW officials)

Chattak Thana
Dr. **Paresh** Chandra Ghosh, MO-EPI, in-charge of THFPO
Md. Nun.11 Anowar, TFPO
Dr. S.M. Abdullah-al-Mamun, MO/MCH-FP
Mr. S. Faizul Haq, Sanitary Inspector
Ms. Shanara **Begum,** Senior, FWV

APPENDIX C: DATA COLLECTION METHODOLOGY AND PLAN

As part of the final evaluation of the Child Health Initiatives for Lasting Development (CHILD) Project, the team will collect information from existing data sources and from individual interviews, group interviews and observations in the field. The data collection will not attempt to be a statistically representative sample but will attempt to be representative of what is happening in CHILD and Non-CHILD Thanas. Instruments for all the interviews and observations are attached to this plan.

The purpose of the data collection is to provide information not only on how the CHILD Project has done in five Thanas of Sylhet, but also to see what the difference is between CHILD and Non-CHILD areas.

In order to do this, field visits will be made to a minimum of two Thanas (as many of the THFPOs and TFPOs as possible from the CHILD areas) and 5-6 Unions within the Thana. Further one Non-CHILD Thana and 2 Unions in the Thana, in Sylhet District, as well as one Non-CHILD area outside of Sylhet District but within the greater Sylhet area (2 Unions). This will better enable the team to assess the unique impacts of the CHILD Project.

The choice of the Non-CHILD Thanas and Unions to visit will be guided by the purpose of trying to select Unions that are similar in characteristics to the CHILD Thanas/Unions so that differences that are observe can be attributed to the CHILD Project.

Within the CHILD areas, the emphasis will be on seeing areas that are doing well and areas that may not be doing as well. This will allow the team to assess what is happening within the CHILD Project. Specific criteria to be used for the selection will be to rank Thanas (and Unions if possible) based on the percentage of infants vaccinated for measles, contraceptive use, and percent of FWA post filled.

It should be noted that all of this planning needs to be validated upon arrival in Sylhet as the local conditions (Monsoon Rain, Clinic Schedules etc.) will only be know to the team on arrival in Sylhet.

Individual Interviews will be carried with the following people:

National Level:

DG Health, DG Family Planning, PD-EPI, PD-CDDP, Director PHC, Director MCH/FP

Sylhet District Level and outside Sylhet District:

Civil Surgeon, Deputy Civil Surgeon, DD-FP, AD-CC, EPI Supervisor, MO-CDDP,

Thana Level in Sylhet District and one Thana outside of Sylhet:
THFPO, EPI Technician, TFPO, MO(MCH)/FP, MO-EPI/HI, and Senior FWV

Union Level in Sylhet District:
AHI, FPI, FWVs in FWC and MO or person in charge of HFWC

CHILD/CARE Staff in Sylhet District:
Public Health Physician, Training Officer, Technical Officer, Project Officer and CARE Sub Office Administrator

Additionally there will be group interviews with key members of the community (Mothers and Informal Leaders, including outreach caretakers) front line MOHFW Workers (HA, FWA), other community workers (TBA, Village Doctors and NGO workers) and CHILD front line workers (FTs and FEs)

Finally there will be observations of outreach. satellite. and combined services clinics, within Sylhet and outside of Sylhet, as well as the CHILD suboffices and EPI Rooms/Control Rooms at the Thana Level. The number and types of clinics that are visited will depend on the schedule of clinics and the weather at the time. Ideally one clinic will be visited for each Union visited. To the extent possible health education activities (child to child and yard sessions in the community) will also be observed,

Separately the Team Leader will observe to what extent programmatic information, that is being collected by CHILD and MOHFW, is being used by all levels of field workers.

Other contacts that may be useful are the MO Pouroshova, TNO, Union Chairman, Grameen Janakayllan. If available, and time permits, these people will be informally interviewed to see what they know of the CHILD Project and its impact.

APPENDIX D: DATA COLLECTION INSTRUMENTS

Form #1

KEY INFORMANT INTERVIEW:
DISTRICT AND CHILD THANA OFFICERS

1. PROJECT KNOWLEDGE: What do you know about the CHILD project?

2. KEY CONTRIBUTIONS: How has the CHILD Project helped to achieve the MOHFW Goals and Objectives in your District/Thana?

3. KEY CONTRIBUTIONS: What are the CHILD Project Contributions to your everyday work? (Probe for Child Staff work with the most)

4. (DISTRICT OFFICERS) IMPACT: What differences do you see between project and non-project Thanas ?

5. SUSTAINABILITY: What would happen if in CHILD Thanas if no more funding was available from USAID via CARE (Immediately and one year from now)?

6. FUTURE: What would you like to see CHILD do over the next four years (suggestions to add to or change about the project to make it more effective)?

7. Is there anything else you want to tell us or ask us about this evaluation and or the CHILD Project?

Form #2

KEY INFORMANT INTERVIEW:
DISTRICT AND NON-CHILD THANA OFFICERS

1. PROJECT KNOWLEDGE: What do you know about the CHILD project?

2. KEY CONTRIBUTIONS: How has your progress to achieve the MOHFW Goals and Objectives, particularly in FP and EPI, in your District/Thana progressed in the last four years?

3. KEY CONTRIBUTIONS: Are there any contributions outside of the MOHFW (NGO, bilateral assistance, etc.) that have contributed to your everyday work and progress to goals and objectives?

4. (DISTRICT OFFICERS) IMPACT: What differences do you see over the last four years in the Thana(s) for which you are responsible?

5. SUSTAINABILITY: Is the progress that you have made over the last four years going to be maintained and improved upon in the future?

Form #3

KEY INFORMANT INTERVIEW:
CARE STAFF

1. INSTITUTIONAL CAPACITY: Who is(are) your counterpart(s) in the MOHFW? (i.e. the person or persons who you interact with on a regular basis and to whom you are transferring skills) (probe for any specifics of changes affected or problems encountered)

2. What are the unique contributions that CHILD had made to helping the MOHFW achieve its goals and targets.

3. What differences do you see in CHILD Thanas/Unions over the last four years of the CHILD Project? (Probe for what can be uniquely attributed to CHILD)

4. Do you think that the present quality of services will be maintained without CHILD assistance to the Thana/Union by your counterparts from question No. l? Please tell why you think (yes or no) as you do.

5. What are the future directions CHILD II should take over the next four years?

6. Do you have any personal stories about specific ways that CHILD has changed the lives of Project beneficiaries (at the level of the community, MOHFW, etc.)?

Form #4

KEY INFORMANT INTERVIEW:
HEALTH & FP WORKERS

(CHILD area)

Location _____ Date _____
PersonsInterviewed _____ Designation _____

l.PROJECT KNOWLEDGE: What do you know about the CHILD project?
2.KEY CONTRIBUTIONS: What do you feel is one of the most important things this project has done?

3. ACHIEVEMENTS:
   a. What has the project changed in your work area?
   b. How has your own work practice changed since the project started?
   c. What do you think about having a CARE partner to work with and how has it helped you or been a problem?

4. OBSTACLES: What obstacles/problems do you have in working with an external NGO:
   a. change in relationship between worker and GOB supervisors
   b. increased complaints from communities

5. IMPROVEMENTS: What would you suggest to add to or change about the project to make it more effective?

6. COMMUNITY:
   a. When the project started, how did you solve the community problems you identified?
   b. How have things changed in terms of your linkages with the community?
   c. What has been CHILD's impact in this relationship?
   d. What do you want the community to do to help you?
   e. How do you think you can become closer to the community?

7. TRAINING:
   a. Have you received any training from GOB/on-job training from GOB/CHILD in the last **3 years?**
   b. Have you received any of this training from CHILD?
      i. What type?
      ii. What new things did you learn from this training/on-job training?
      iii. How did you apply them in your job?
      iv. What did you think about this training?

8. SUSTAINABILITY:
   a. If CHILD support were to be discontinued what would happen to your work?
   b. If CHILD support were to be discontinued what would be the community impact?

9. Is there anything else you want to tell us or ask us?

Form #5

KEY INFORMANT INTERVIEW:
HEALTH & FP WORKERS
(non-CHILD area)

Location _____ Date _____
PersonsInterviewed _____ Designation _____

1. PROJECT KNOWLEDGE: Did you know that a CARE project was going on in some other thanas in Sylhet district?

2. KEY CONTRIBUTIONS: (If yes) What is one of the most important things this project has done (you have heard and/or learned, how?)

3. COMPARABLE:
   a. What has the GOB project changed in your work area during last three years?
   b. How has your own work practice changed since 1991?

4. IMPROVEMENTS: What would you suggest to add to or change about the GOB project to make it more effective?

5. COMMUNITY:
   a. How do you solve the community problems you identified?
   b. How have things changed in terms of your linkages with the community since 1991?
   c. What has contributed to this impact?
   d. What do you want the community to do to help you?
   e. How do you think you can become closer to the community?

6. TRAINING:
   a. Have you received any training/on-job training in the last 3 years?
      i. What type?
      ii. What new things did you learn from this training/on-job training?
      iii. How did you apply them in your job?
      iv. What did you think about this training?

7. SUSTAINABILITY:
   a. Is the progress that has been made over the last four years going to be maintained and improved upon in the future?

Is there anything else you want to.tell us or ask us?

Form #6

COMMUNITY INTERVIEW

Both CHILD and non-CHILD areas

Location _____ Date _____
Information on Person(s) Interviewed _____

A) General

1. What do you know about the CARE project?
2. What do you feel is one of the most important things this project has done for your and your community? (CHILD *only)*
3. What has the project changed in your community? *(CHILD only)*
4. What changes have you noticed in the worker's practices in your area since 1991?
5. Before 1991 how did you solve the health problems you identified?
   a. where to go for immunizations
   b. where to get FP supplies
6. How have things changed in terms of your linkages with the GOB workers since 1991?
7. How do you think you can become closer to the workers?
8. What do you think the CARE project should help you with?
9. How does the MOHFW help you take care of health concerns?
10. What changes may take place if the CARE project discontinues? (CHILD only)
11. Is the progress that have been made over the last four years going to be maintained and improved upon in the future?
12. Is there anything else you want to tell us or ask us?

B) Additional

i) Mothers Group

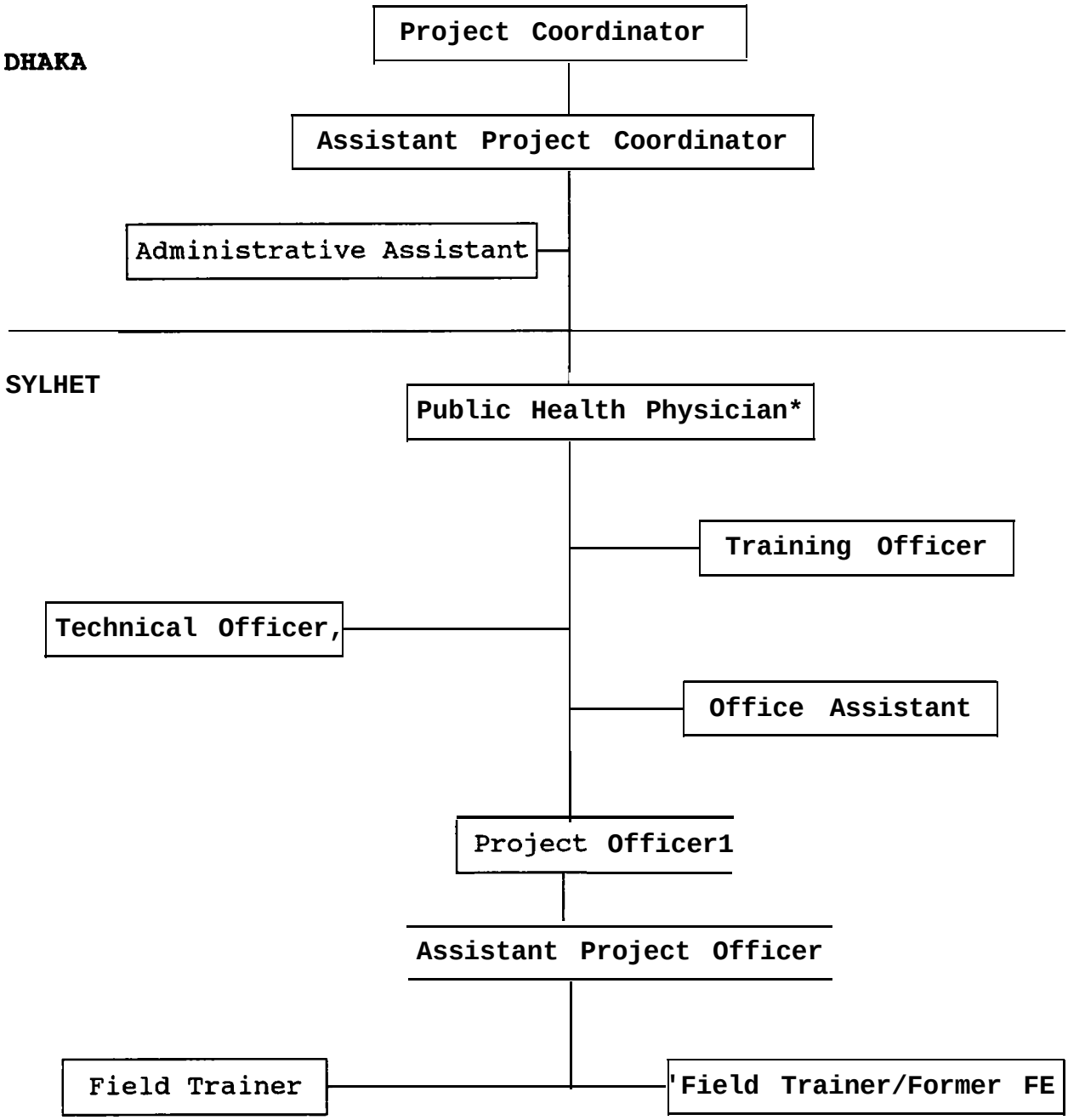
13. What is your attitude towards ORT, Immunization, Nutritional and FP/MCH program of the H&FW workers?
14. Did your attitude changed during the last three years? If it is positive, how and what are those changes?
15. Is your opinion different from the males of your family/community? If it is positive, how and what are those differences?

ii) Informal Leader/ SC household owner

16. Did you take part in the decision making process in the selection process of EPI outreach sites/SC/ merged sites?
17. Does CARE project help anyway to organize, maintain and improve the EPI outreach sites/SC/ merged sites?
18. Did you get any benefit and/or negative return from your cooperation with H&FP workers?

Comment on the worker's relationships with the community (known, accepted, etc)

APPENDIX E: ORGANIZATIONAL CHART: CHILD Project



* Also the Project Manager

APPENDIX F: LIST OF KEY DOCUMENTS

LIST OF KEY DOCUMENTS

	Name of the Document	Publication Date
1.	Baseline Survey Report	October 1991.
2.	CHILD Survival VIII Proposal	December 1991.
3.	Follow-up K&P Survey Report	January 1993.
4.	Detail Implementation Plan (CHILD)	March 1993.
5.	Mid Term Evaluation Survey Report	February 1994.
6.	Mid Term Evaluation of CHILD Project	April 1994.
7.	Situational Analysis of New Thanas of Sylhet District	August 1994
8.	The Determinants of Reproductive Change in Bangladesh	June 1994.
9.	Project Proposal CHILD-II	November 1994
10.	Draft CHILD Final Survey Report	July 1995